Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Lee Carrow
2. Date of Death: Month July Day 27, Year 2001
3. Time of Death: 8:30pm
4a. Facility Name (If not institution, give street end number): 529 Crisfield Rd.
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218 28 2247
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 1, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 529 Crisfield Rd.
10f. Zip Code: 21220
10g. Citizen of What Country: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1953/56
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Forklift Operator
16b. Kind of Business/Industry: Western Electric

17. Father's Neme (First, Middle, Last): Grover Carrow
18. Mother's Neme (First, Middle, Maiden Surneme): Bertha Copper

19a. Informent's Neme/Relationship (Type, Print): Anna Pearl Carrow (Wife)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 529 Crisfield Rd. Baltimore, Md. 21220

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Oak Lawn Cemetery
Dete: 7/31/2001
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Servica Licensee: John W. Burkowske MO1091
22. Neme end Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Cancer lung — Approximate Interval: 1 yr 4 mths
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and menner steted.

29b. Signeture and title of certifier: MD
29c. License number: D16487
29d. Dete signed (Month, Day, Year): 7/30/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): MYO THANT 2114 SANDPIPER CIRCLE, SUITE 211, BALTO, MD 21236

State Registrar

31. Date filed (Month, Dey, Year): JUL 31 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 19a PER FH G798 08/14/01

Certificate of Death

RR

Reg. No. 2001 24002

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
YOUNG	YONG	CHO	JULY 29, 2001	11:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOSEPH RITCHIE HOSPICE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
624-24-3662	1☒M 2☐F	68 Yrs.			OCT. 30, 1932	SOUTH KOREA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HOWARD	ELLICOTT CITY	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2609 JONATHAN ROAD	21042	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		PAINTER	POWER CORPORATION

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
DO	SONG	CHO	MONG	SUN	CHUNG

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. ~~EUN~~ EUN CHO (WIFE)	2609 JONATHAN ROAD, ELLICOTT CITY, MARYLAND 21042

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	LAKEMONT MEMORIAL PARK	8/2/2001	DAVIDSONVILLE, MD.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic Prostate Carcinoma	8yrs
	Due to (or as e consequenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest	b. Due to (or as a consequenca of):	
	c. Due to (or es a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Inpt Hospice

27. Menner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examinetion and/or Investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D33400	07/30/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Iredell W. Iglehart III MD 500 W University Pkwy Baltmroe MD 21210

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signature
JUL 31 2001	[signature] G. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

11:45 pm

7/29/01

Young Cho

10

DHMH 16 Rev 6/95

ORIGINAL

01-4185-510
JACQUELINE V. CANADA
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24003

UNPENDED 082201:ITEMS# 23a,27,28a-f per ME G798 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACQUELINE V. CANADA
2. Date of Death: Month JULY, Day 24, Year 2001
3. Time of Death: 2145
4a. Facility Name (If not institution, give street and number): 4232 PARK HEIGHTS AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-58-2166
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 9-9-1950
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4232 PARK HEIGHTS AVE
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): ALEXANDER Ryce
18. Mother's Name (First, Middle, Maiden Surname): Josephine SHANNON

19a. Informant's Name/Relationship (Type, Print): CHARLES RYCE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code):

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 7-2101
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Willie E. Howell Jr
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGTS. BALTO. MD 21207

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METHADONE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year): Found: 7-24-01
28b. Time of Injury: Found: 9:30p M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4232 Park Heights Ave. apt. B, Balto., MD

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. M. T.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JULY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: ▶ Brenda G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELEANOR L. COATES

2. Date of Death: Month JUL Day 25 Year 2001

3. Time of Death: 1620 M

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 321-26-3942

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06/01/1917

9. Birthplace (State or Foreign Country): ILLINOIS

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 713 MAIDEN CHOICE LANE

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NUTRITIONIST

16b. Kind of Business/Industry: NUTRITIONIST

17. Father's Name (First, Middle, Last): TEIS VELDE

18. Mother's Name (First, Middle, Maiden Surname): LAURA STRARRETT

19a. Informant's Name/Relationship (Type, Print): ROBERT SLOAN(ATTY.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 ST. PAUL ST. SUITE 1400 BALTO.,MD. 21202.

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY

Date: 07/27.

20c. Location - City or Town, State: 2001 BALTO.,MD.

21. Signature of Funeral Service Licensee: ▶ William Davis III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPTIC SHOCK — 24 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

URINARY TRACT INFECTION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one)

Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D-13592

29d. Date signed (Month, Day, Year): JUL. 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEXANDER JOHNSON, 900 CATON AVE. BALTIMORE 21229

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Coates, Eleanor

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Death Month	Day	Yeer	3. Time of Death
Barbara	A.	Comegys	JULY	26	2001	04:10 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
Uion Memorial Hospital(Union)	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplece (State or Foreign Country)
216-40-0661	1☐M 2☒F	59 Yrs.					4/8/42	S.Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.		Baltimore	1☒Yes 2☐No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
5623 Groveland Ave.	21215	USA

11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Custodian	Balto City.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Furman Anderson	Bessie Anderson

19a. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Comegys Husband	5623 Groveland Ave, Baltimore, Md. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Loudon Park Cem.	7/31/01	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Lloyd M. Estep	Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 days
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	Due to (or as a consequence of): b. Renal Failure	3 days
	Due to (or es a consequence of): c. Pneumonia	3 days
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.
2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Laverdis Davis Medical Doctor	AT2438946012	July 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Laverdis Davis 201 East University Parkway, Baltimore Maryland 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ Patricia D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24006

Patient known as Edith Craddock

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDITH MAE CRADDOCK		2. Date of Death (Month, Day, Year): July 22, 2001	3. Time of Death: 0415
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore	4b. City, Town, or Location of Death: Baltimore	4c. County of Death: N/A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-22-7331	1☐ M 2☒ F	88 Yrs.			9-29-1912	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5508 NARCISSUS AVE.	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-0-	HOUSEWIFE	DOMESTIC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN CAGLE	ANNIE ROSS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ETHEL STEVENSON(DAUGHTER)	5508 NARCISSUS AVE. BALTIMORE, MARYLAND 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ARBUTUS MEMORIAL PARK	7-27-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jonathan D. Hubner	PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial infarction	30 mts
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Hypertension	years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Tariq Khan MD	D21730	July 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tariq Khan Sinai Hospital Baltimore

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24007

Peggy Daniels

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
PEGGY DELORES DANIELS	JULY 28 2001	4:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MERCY AT STELLA MARIS HOSPICE	BALTIMORE	N/A

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-3848	1☐ M 2☒ F	77 Yrs.			JAN. 16, 1924	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1109 SOMERSET STREET	21202	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4 YRS		SOCIAL WORKER	DEPT OF PUBLIC WELFARE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
RICHARD JACKSON SR.	PIRCY DORN

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DARLENE DANIELS (DAUGHTER)	1109 SOMERSET ST., BALTIMORE MD. 21202

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ARBUTUS CEMETERY	8-2-01	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Renal Failure	
Due to (or as a consequence of):	b. Dehydration	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Poor feeding	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Anemia
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D0035674	July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Windell Simmons-Clemmons 6210 Belair Road Baltimore Md 21206.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#21 perFHG798 8/13/01 EW

Certificate of Death

Reg. No. 2001 24008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leon Duker

2. Date of Death Month: 6 Day: 29 Year: 2001

3. Time of Death: 1855

4a. Facility Name (If not institution, give street and number): SunBridge Care and Rehab for Elkton

4b. City, Town, or Location of Death: Elkton MD

4c. County of Death: Cecil County

Funeral Director

5. Social Security Number: 221-16-8749

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 3, 1924

9. Birthplaca (State or Foraign Country): Delaware

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Kent

10c. City, Town or Location: Golts

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 13459 Goates Caldwell Road

10f. Zip Code: 21637

10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedant's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 8 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Businass/Industry: Construction

17. Fathar's Nama (First, Middle, Last): Ephrain Ducker, Sr.

18. Mothar's Nama (First, Middla, Maidan Sumama): Irene Byard

19a. Informant's Name/Ralationship (Type, Print): Marilyn Watson Duker /Niece

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): P.O.Box 315, Townsend, Delaware 19734

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stete 4 [ ] Donetion 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of cemetary, cremetory or other place): Ebenzer Cemetery

Data: 7/5/2001

20c. Location - City or Town, State: Townsend, Delaware

21. Signatura of Funaral Service Licensee: John A. Prince perDVR

22. Nama end Addrass of Facility: Bennie Smith Funeral Home, 717 W. Division Street, Dover, Delaware 19904

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha deeth. Do not entar tha moda of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only ona causa on aach lina.

Approximata Intarval Batween Onsat end Death

Immediata Causa (Final diseesa or condition resulting in death): a. CARDIAL ARRYTHMIA

Dua to (or es a consequenca of): CAD

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Ceuse (Diseesa or injury that initieted evants rasulting in death) Last:

b. Due to (or es a consequence of):

c. Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: ANOXIC BRAIN INJURY

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings aveilable prior to complation of cause of death? 1 [ ] Yas 2 [X] No

25. Wes case rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Invastigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledga, death occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and piece, end due to the ceuse(s) and mannar stated.

29b. Signature and titla of certifier: A Flow MD

29c. Licansa number: DE C1000 4131

29d. Data signed (Month, Day, Year): July 16 2001

30. Nama and addrass of person who completed causa of daeth (Item 23a) (Type, Print): ARLON STONE, MD 817 CHURCHMANS CIR NEWCASTLE DE 19720

State Registrar

31. Data filad (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Geneva B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24009

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Jorge		Delcid	July 27 2001	19 19 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
THE Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (If yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
n/a	1 [X] M 2 [ ] F	0 Yrs.		8 –	July 27, 2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Ellicott City	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8766 Town & Country Blvd. Apt. A	21043	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [X] Yes 2 [ ] No Specify: El Salvadore	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	n/a	n/a

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jorje C. Delcid	Lauren Buckley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lauren Buckley-mother	8766 Town & Country Blvd. Apt. A, Ellicott City, Md 21043

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)	St. John's Cemetery	07/30/2001	Ellicott City, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kim Schlang, Mosd	Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Brain Herniation	1 hour
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b. Due to (or as a consequence of): Intra Cranial Hemorrhage	12 hours
	c. Due to (or as a consequence of): Brain Tumor	9 months
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Gary Gallia MD PhD	RES-000	July 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY GALLIA 600 North Wolfe Street Baltimore, Md 21287

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
JUL 31 2001	▶ P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24010

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MINNA DOUGHERTY

2. Dete of Deeth — Month: 7 Dey: 28 Yeer: 2001

3. Time of Death: 8:30 pm

4e. Feciility Neme *(If not institution, give street end number)*: Ridgeway Manor

4b. City, Town, or Locetion of Death: Catonsville

4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 214-40-4405

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 94 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 07-11-1907

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: MD.

10b. County: Howard

10c. City, Town or Locetion: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4933 Grace Court

10f. Zip Code: 21043

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Collage (1-4or 5+): 3

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher/Librarian

16b. Kind of Business/Industry: Education

17. Fether's Neme *(First, Middle, Last)*: Charles Weidenhammer

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Catherine Link

19e. Informent's Neme/Reletionship *(Type, Print)*: Karen Beuchel-granddaughter

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6517 Abel Street, Elkridge, MD. 21075

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: Loudon Park Cemetery

Dete: 08-01 2001

20c. Locetion - City or Town, Stete: Baltimore, MD.

21. Signeture of Funerel Service Licensee: [signature]

22. Neme end Address of Feciility: Witzke Funeral Home/Catonsville 1630 Edmondson Ave., Baltimore, MD. 21228

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Subacute Subdural Hematoma — Few wks

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

Hypothyroid

Atrial fib, diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Streat and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature]

29c. License number: D19667

29d. Dete signed *(Month, Dey, Yeer)*: 7-29-2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Michael Schwartz - Ridgeway Manor, 5143 Edmondson Ave. Catonsville, MD. 21228

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUL 31 2001

32. Registrar's Signeture: [signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours after death.

To the Funeral Director: After this certificete hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
John Joseph Delaney, Jr.	JULY 28 2001	905 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST AGNES HEALTHCARE	BALTIMORE, MARYLAND	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
214-18-0509	1 [X] M 2 [ ] F	80 Yrs.			Jan.,14,1921	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Catonsville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
719 Maiden Choice Lane BR 241	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 09-29-1942 12-01-1945	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Technician	American Totalisator

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John J. Delaney, Sr.	Margaret Krausz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Mary C. Bossle-daughter	10121 Lakeside Ct., Ellicott City, MD. 21042

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Lorraine Park Cemet.	08-01-2001	Woodlawn, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kimi Schlanger M0120	Witzke Funeral Home/Catonsville 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. TOXEMIA	2 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. RENAL FAILURE Due to (or as a consequence of):	2 WEEKS
	c. DIABETES MELLITUS Due to (or as a consequence of):	10+ YEARS
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC (L) LEG

CONGESTIVE HEART FAILURE

RECENT MYOCARDIAL INFARCTION

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
N/A	N/A M	1 [ ] Yes 2 [ ] No	N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ [signature], MD	P 14513	JULY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTIAN BUTZNER, MD

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
JUL 31 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME John Delaney, Jr.

15

01-4172-510
CJ
Ronald Dunn

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald E. Dunn, Sr.

2. Date of Death: Month: July; Day: 24; Year: 2001

3. Time of Death: 04:10 P.M.

4a. Facility Name (If not institution, give street and number): 301 McMechen Street # 603

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 039-22-3328

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR 30, 1934

9. Birthplace (State or Foreign Country): Rhode Island

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 301 McMechen Street #603

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Financial Planner

16b. Kind of Business/Industry: Westinghouse/ Control Data

17. Father's Name (First, Middle, Last): John Dunn

18. Mother's Name (First, Middle, Maiden Surname): Ina Brewster

19a. Informant's Name/Relationship (Type, Print): Ronald E. Dunn, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7909 49th Avenue North, St. Petersburg, FL 33079

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 7-27-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): July 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24013

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Chesney de Groat
2. Date of Death (Month, Day, Year): July 27, 2001
3. Time of Death: 2:15 AM
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 142-03-5084
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APR 13, 1910
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 825 Market Street
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Labor
16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: George de Groat
18. Mother's Name *(First, Middle, Maiden Surname)*: Jessie Chesney

19a. Informant's Name/Relationship *(Type, Print)*: William C. de Groat/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6357 Burchfield Avenue Pittsburgh, PA 15217

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.
Date: 7-28-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiomyopathy
Due to (or as a consequence of):
b. coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
aspiration pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D31712
29d. Date signed *(Month, Day, Year)*: 7/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECK JR 219 W BEL AIR AVE. ABERDEEN MD 2001

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 31 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Dr. Eck

DeGroat, William 0215

#12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernard J. Eckart
2. Date of Death: Month July Day 25 Year 2001
3. Time of Death: 13:35
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-2071
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 17, 1930
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: FERNDALE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 200 FERNDALE AVENUE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-1954
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROJECT MANAGER
16b. Kind of Business/Industry: ANNE ARUNDEL COUNTY PUBLIC SCHOOL SYSTEM

17. Father's Name (First, Middle, Last): CHARLES CHRISTOPHER ECKART
18. Mother's Name (First, Middle, Maiden Surname): ANNA LORETTA NICKOLS

19a. Informant's Name/Relationship (Type, Print): MRS. ELAINE C. ECKART (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 FERNDALE AVENUE, FERNDALE, MARYLAND 21061

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK Date: 7/30/2001
20c. Location - City or Town, State: ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: M00795
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	12 hours
Due to (or as a consequence of): b.	Pulmonary Embolism	24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Non-Small cell Carcinoma of the Lung	10 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John J. Lee
29c. License number: Res-000
29d. Date signed (Month, Day, Year): July 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John J. Lee 600 N. Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
ELIZABETH		FACCHINE	July 27 2001	1114A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
159-24-2431	1☐M 2☒F	72 Yrs.			Nov. 24, 1928	Pennsylvania

To Be Completed by Funeral Director

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Clarksville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13610 Meadow Glenn	21029	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Chief of Publications	F.D.A. Bureau/Radiological Hlth

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Frances Copella	Mary Glayds Buckley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kevin Facchine/Son	5421 Denberg Lane Raleigh, North Carolina 27606

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Fairfax Mem. Park	07/31/2001	Fairfax, Virginia

21. Signature of Funeral Service Licensee: [signature] MA1142

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. myocardial infarction	one day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in daath) Last	Due to (or as a consequence of): b. Thoracoabdominal aortic dissection	three months
	Due to (or as a consequence of): c. Thoracoabdominal aortic aneurysm	six years
	Due to (or as a consequence of): d. hypertension	thirty years

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

abdominal compartment syndrome

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. ☐2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theresa Lynn Hartsell MD, PhD	RES-000	July 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theresa Lynn Hartsell, MD PhD 600 North Wolfe ST. Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	[signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No: 2001 24016

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Leo Anthony Flynn	July 27 2001	1:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Armacost Nursing Home	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
523-07-0660	1 [X] M 2 [ ] F	81 Yrs.			November 20, 1919	Colorado

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6608 Sharon Road	21239	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No 1941-1945	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Commercial Artist	Sign Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Michael Flynn	Cora Weisbeck

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joanne F. Lippy (Daughter)	6608 Sharon Road Baltimore, Maryland 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Dulaney Valley Mem. Gdns.	July 30, 2001	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven T. Bittle	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Atherosclerotic Cardiovascular disease	years
	c. Due to (or as a consequence of): —	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Amatun M Naeem MD.	D15503	July 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AMATUN M NAEEM 501 Dolphin st, Balto, MD 21217

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ Denise D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JAMES CLARENCE GASKINS JR.	July 28 2001	945 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-30-5752	1☒M 2☐F	69 Yrs.		3-13-1932	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
701 ARLINGTON AVE.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-8-	-0-	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
JAMES C. GASKINS SR.	LILLIAN H. HARRIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MELISANDE BREWER(COUSIN)	439 JOAN ST. SOUTH PLAINFIELD, NEW JERSEY 07080

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BALTIMORE NATIONAL	7-31-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jonathan D. Hubner	PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart faifure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Probabk Myocardial Infarction	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	23d. Dete ot delivery Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Edward Seidel MD	D38956	July 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward Seidel MD, 5601 Loch Raven, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Bernard P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Francis Hackman, Sr.

2. Date of Death (Month, Day, Year): July 27 2001

3. Time of Death: 9:05 PM

4a. Facility Name (If not institution, give street and number): Forest Haven Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-16-3583

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 8 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: PA

10b. County: York

10c. City, Town or Location: Shrewsbury

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 47 Brook Meadow Circle

10f. Zip Code: 17361

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): John H. Hackman

18. Mother's Neme (First, Middle, Maiden Surname): Marie Stoll

19a. Informant's Name/Relationship (Type, Print): Harry F. Hackman / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 Brook Meadow Circle, Shrewsbury, PA 17361

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 7/30/01

20c. Location - City or Town, State: Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CEREBRO VASCULAR

Due to (or as a consequence of): DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tasneem Lakhani

29c. License number: D28595

29d. Date signed (Month, Day, Year): 7/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Geneva D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

REPLACEMENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED 110201: ITEM#1 per ME G801 ss

Certificate of Death

Reg. No. 2001-24019

PLEASE NOTE: This death certificate was created as a replacement. The original death certificate was misplaced along with the Query and permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 documentation. georgie price 10/31/2001

Physician /Medical Examiner | **Funeral Director** | **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Robert Ernest Hobson (~~Robert~~ ~~Hobson~~)						2. Date of Death Month Day Year: July 25, 2001		3. Time of Death: 1857p M
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital			4b. City, Town, or Location of Death: Baltimore			4c. County of Death: NA		
5. Social Security Number: 244-05-0485	6. Sex: 1 [X] M 2 [ ] F	7. Age (In yrs. last birthday): 85 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.		8. Date of Birth (Month, Day, Year): 12-15-15		9. Birthplace (State or Foreign Country): VA
Usual Residence of Decedent								
10a. State: MD	10b. County: NA	10c. City, Town or Location: Baltimore				10d. Inside City Limits: 1 [X] Yes 2 [ ] No		
10e. Street and Number: 2438 E. Biddle Street		10f. Zip Code: 21213				10g. Citizen of What Country?: USA		
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th / College (1-4or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shipyard				16b. Kind of Business/Industry: Bethlehem Steele Co.		
17. Father's Name (First, Middle, Last): John Artis						18. Mother's Name (First, Middle, Maiden Surname): Edith Hampton		
19a. Informant's Name/Relationship (Type, Print): Courtney Hobson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box #25084 Baltimore, Maryland 21229						
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk. Cem.			Date: 07-31-01	20c. Location - City or Town, State: Arbutus, MD		
21. Signature of Funeral Service Licensee: per DVR ▶ Vanessa Coad		22. Name and Address of Facility: Wm. C. March FH 1101 E. North Avenue, Baltimore, Maryland 21202						

Physician /Medical Examiner | **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPHYXIA DUE TO AIRWAY TUBE MALPOSITION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
7-25-01	Unknown M	1 [ ] Yes 2 [X] No	Airway Tube Malposition

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Nursing Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 22 S. Athol Ave., Baltimore, MD

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Theodore M. King M. D. Theodore M. King M.D.	O.C.M.E.	October 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore M. King 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 31 2001

Signature of Registrar's Signature ▶

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

01-4105-003
Norman P. Howe
MNMR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 091801:ITEMS#23a,27 per ME G799 SS

Certificate of Death

Reg. No. 2001 24020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norman Duane Howe

2. Data of Death — Month: July; Day: 20; Yaar: 2001

3. Tima of Death: 950 am

4a Facility Nama *(If not institution, giva street and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 365-50-0834

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Undar 1 Yaar — Months: ; Days:

If Undar 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: May 22, 1952

9. Birthplace *(Stata or Foraign Country)*: Mich.

Usual Rasidance of Dacedant

10a. Stata: MI

10b. County: Jackson

10c. City, Town or Location: Jackson

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 1734 E. South Street

10f. Zip Code: 49203

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [ ] Married 3 [ ] Widowad 4 [X] Divorcad

12. Was Decedent Evar in U.S. Armad Forcas? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amaricen Indian, Black, White, atc. *Specify:* White

15. Decedant's Educetion *(Specify only highast grada complatad)* — Elementary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Driver

16b. Kind of Businass/Industry: Trucking

17. Father's Nama *(First, Middla, Last)*: Norman Dale Howe

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Francis Ann Imboden

19a. Informant's Name/Ralationship *(Type, Print)*: Scott Howe - son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 3014 Whitlock Jackson, MI 49201

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [X] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Roseland Memorial Gardens — Data: 07-26-2001

20c. Location - City or Town, Stata: Jackson, MI

21. Signatura of Funaral Sarvica Licensea: Kim Schlanger Mabee

22. Nama and Addrass of Facility: Witzke Funeral Home/Catonsville 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each lina.

Approximata Intarval Batwaen Onsat and Daath

Immadiata Causa (Final disaasa or condition resulting in daath)
a. DILATED CARDIOMYOPATHY
Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Cause (Disease or injury that initiated evants resulting in death) Last
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [ ] No

24b. Wara autopsy findings available prior to complation of ceusa of death? 1 [ ] Yas 2 [ ] No

25. Was cesa rafarrad to medical examiner? 1 [X] Yas 2 [ ] No

26. Piece of Death *(Check only ona)* — Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)* 1 [ ] **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to the ceuse(s) and mannar as stated. 2 [X] **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and due to the ceuse(s) and mannar stated.

29b. Signatura and title of certifier: Marguerite McGrath

29c. Licansa number: O.C.M.E.

29d. Data signad *(Month, Day, Year)*: July 21, 2001

30. Nama and addrass of parson who completed ceusa of death (Item 23a) (Type, Print): MARY SMITH P. KOLOUS MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 31 2001

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24021

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ODESSA HILTON
2. Date of Death Month / Day / Year: JULY 29, 2001
3. Time of Death: 8:27am
4a. Facility Name *(If not institution, give street and number)*: JOSEPH RITCHIE HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-40-1441
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5-20-1941
9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residance ot Dacedant

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1729 BRADDISH AVE.
10f. Zip Coda: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☐ No If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* BLACK

15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): -12- / College (1-4or 5+): -0-
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: RECEPTIONIST
16b. Kind of Business/Industry: MANUFACTURING

17. Fathar's Nama *(First, Middla, Last)*: CHARLIE PHILLIPS
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: EVOLLA WRIGHT

19a. Informant's Name/Ralationship *(Type, Print)*: STANLEY C. HILTON(SON)
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 3631 liberty heights ave. apt B7 BALTO.MD 21215

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar piece)*: ARBUTUS MEMORIAL PARK
Data: 8-4-2001
20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signature of Funaral Sarvice Licansee: Judith D. Hubner
22. Nama and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona ceusa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in deeth)
a. Cancer of BREAST with Mets + Seizure 2 DAYS
Dua to (or as a consequance ot):
b. with Bone + Brain Mets >2yr.

Sequentially list conditions, if any, laading to immadiata ceuse. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to completion of ceusa of deeth? 1☐ Yas 2☐ No

25. Was cesa retarrad to medical examinar? 1☐ Yas 2☒ No
26. Place ot Deeth *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidence 6☒ Othar *(Specify)* Hospice
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, date and place, and dua to tha ceuse(s) and mannar stated.
29b. Signatura and titla of certifiar
29c. Licansa number: D14221
29d. Data signed *(Month, Day, Year)*: 7.29.01
30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): T. A. Brown MD 223 E. Biddle Balt MD 21202

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 31 2001
32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

7/29/01 @ 8:57 Am
Odessa Hilton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): METTIE V. IRELAND
2. Date of Death (Month, Day, Year): JULY 27 2001
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE HAMMONDS LANE
4b. City, Town, or Location of Death: BROOKLYN PARK
4c. County of Death: ANNE ARUNDEL COUNTY

Funeral Director

5. Social Security Number: 213-03-7878
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 06 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3732 St. Margaret Street
10f. Zip Code: 21225
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home Owner

17. Father's Name (First, Middle, Last): Louis Lewis
18. Mother's Name (First, Middle, Maiden Surname): Ester Anderson

19a. Informant's Name/Relationship (Type, Print): Steven J. Ireland (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1903 Larch Court, Edgewood, Md. 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk.
Date: 8/01/2001
20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Thomas S. Polyniak
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D 21776
29d. Date signed (Month, Day, Year): JULY 30 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUMA P. MUNDRA MD 3001 SHANOVER ST BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#19a perFHG798 8/3/01 EW
Amend Item#19a perFHG798 8/2/01 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA ICHNIONSKI
2. Data of Death — Month: July Day: 30 Year: 2001
3. Time of Death: 7:05 AM
4a. Facility Name (If not institution, give street and number): KESWICK MULTICARE CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-32-2235
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 13, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4001 Roundtop Road
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade — College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Adjuster
16b. Kind of Business/Industry: Hutzlers Department Store

17. Father's Name (First, Middle, Last): Walenty Ichniowski
18. Mother's Name (First, Middle, Maiden Surname): Mary Tomaszkiewicz

19a. Informant's Name/Relationship (Type, Print): Rev. Stephen E. ~~Jeselnik, Nephew~~ Jeselnick Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4001 Roundtop Road Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: 8/2/01
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton — ▶ Christina L. Hilton
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic malignant melanoma — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Isabelle MacGregor
29c. License number: D13657
29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M ISABELLE MACGREGOR, 7001 W. 40TH STREET. BALTIMORE MD 21211

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: ▶ Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE DELVA JUPITZ
2. Date of Death: Month JULY Day 30 Year 2001
3. Time of Death: 3:25 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 215-70-7481
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): Nov. 24, 1922
9. Birthplece (Stete or Foreign Country): WV

Usuel Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14-7 Haubert Street
10f. Zip Code: 21230
10g. Citizen of Whet Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): James Lambert
18. Mother's Name (First, Middle, Maiden Surneme): Lettie F. Murphy

19a. Informant's Name/Relationship (Type, Print): Emil F. Jupitz, Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1407 Haubert Street, Baltimore MD 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Meadowridge Cemetery Date: August 3, 2001
20c. Location - City or Town, Stete: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 2 WEEKS

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last:
b. Due to (or es e consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE
DIABETES MELLITUS

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown
24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Farah, MD, PGY-3
29c. License number: P 13471
29d. Date signed (Month, Dey, Yeer): JULY, 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARINA FARAH, MD 3001 S. HANOVER STREET, BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Dey, Yeer): JUL 31 2001
32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Eugene Jackson	July 14 2001	8:15A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-03-8631	1☒M 2☐F	88 Yrs.			June 21,1913	Washington, D.C

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2101 Fairchild Road	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Supervisor - Paint Company	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unavailable	Daisey Jackson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Saundra Jackson - Wife	1922 Newton Street,NE, Washington, DC 20018-2712

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Washington National Cem	7/20/01	Suitland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] CC0348	Latney's Funeral Home, inc. 3831 Georgia Avenue,NW, Washington, DC 20011

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Pneumonia	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Anemia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D54347	JULY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NEERAJ CHOPRA 121 CONGRESSIONAL LANE #409 ROCKVILLE, MD.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Jendras
2. Date of Death: Month July, Day 29, Year 2001
3. Time of Death: 5:36 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-7162
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 10, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6617 Danville Ave.
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 Years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Delss, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Sophia McNew

19a. Informant's Name/Relationship (Type, Print): Mr. Lawrence W. Jendras (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6617 Danville Ave. Dundalk, Maryland 21222

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 8/1/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 1 week

Due to (or as a consequence of):
b. tamponade — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter Good MD
29c. License number: 21005
29d. Date signed (Month, Day, Year): July, 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Good MD Johns Hopkins Bayview Medical Center

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edgar Laroy Jones
2. Date of Death (Month, Day, Year): July 27, 2001
3. Time of Death: 17:45 M
4a. Facility Name (If not institution, give street and number): Frederick Villa Nursing Ctr.
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 002-03-3648
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 14, 1915
9. Birthplace (State or Foreign Country): Mass.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4010 Alto Road
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Editorial Writer
18b. Kind of Business/Industry: Baltimore Sun

17. Father's Name (First, Middle, Last): Carl Curtis Jones
18. Mother's Name (First, Middle, Maiden Surname): Ruth Kimball

19a. Informant's Name/Relationship (Type, Print): Gertrude Jones / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4010 Alto Rd. Balto.,Md. 21216

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto.-Wash.Crematory
Date: 7-30-01
20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: ▶ Robert J Radach
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd.,Balto.,Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: END STAGE DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jasneem Lakhani
29c. License number: D 28595
29d. Date signed (Month, Day, Year): 7/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: ▶ D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA L. KRAUS
2. Date of Death (Month, Day, Year): July 28, 2001
3. Time of Death: 6:23PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-32-4530
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 10, 1935
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7955 QUEENSROAD
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE MANAGER
16b. Kind of Business/Industry: WHOLESALE TIRE COMPANY

17. Father's Name (First, Middle, Last): ROLAND DENNIS
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE EMERICH

19a. Informant's Name/Relationship (Type, Print): KATHLEEN A. BREACH (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 723 MESQUITE ROAD, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): GLEN HAVEN MEMORIAL PARK | Date: 8/1/2001
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Cardiac arrest	30 minutes
Dua to (or as a consaquenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Coronary Artery disease	6 years
Due to (or as a consequence of):		
c.	Hypertension	30 years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D17743
29d. Date signed (Month, Day, Year): 07/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L. SEENIVASAN, MD, 606 HAMMONDS LN, BALTIMORE, MD, 21225

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

KRAUS Virginia

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24029

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Kucera

2. Date of Death (Month, Day, Year): July 28, 2001

3. Time of Death: 2051

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215-10-4534

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 22 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1237 Maiden Choice Lane

10f. Zip Code: 21229

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Dushel

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Frances Dieter

19a. Informant's Name/Relationship *(Type, Print)*: Charles A. Kucera / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1237 Maiden Choice Lane, Baltimore, Maryland 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park

Date: 8/1/01

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician

29c. License number: D51853

29d. Date signed *(Month, Day, Year)*: July 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Silverman MD 900 Caton Avenue Baltimore 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 31 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Kucera, Helen

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24030

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Kendrick

2. Date of Death Month: July Day: 28 Year: 2001

3. Time of Death: 12:55PM

4e. Facility Name *(If not institution, give street and number)*: 2503 Christian Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-22-8308

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 11 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2503 Christian Street

10f. Zip Code: 21223

10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: William S. Barber

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie A. Miller

19a. Informent's Neme/Reletionship *(Type, Print)*: Della A. Polk / daughter

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 1578 Brimfield Circle, Sykesville, Maryland 21784

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Loudon Park Cemetery

Dete: 8/1/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name end Address of Fecility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Pert1. Enter the disease, ~~or complicetions~~ thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immedeite Ceuse (Final diseese or condition resulting in deeth)

e. Small Cell lung cancer — five months

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immedeite cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Onknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Patrice Green MD

29c. License number: D54018

29d. Date signed *(Month, Dey, Year)*: July 28, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Patrice Green, MD 201 E. University Parkway, Balt., Md 21218

State Registrar

31. Dete filed *(Month, Dey, Year)*: JUL 31 2001

32. Registrer's Signeture: D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

7/28/01 @ 12:55 PM

MARGaret Kendrick

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Steven J. Kurtz

2. Date of Death (Month, Day, Year): July 28, 2001

3. Time of Death: 6:35 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-58-3942

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1952

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 200 Bayside Drive

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1975-77

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Stanley Leon Kurtz

18. Mother's Name (First, Middle, Maiden Surname): Nona Kathryn Engebretson

19a. Informant's Name/Relationship (Type, Print): Barbara Williams (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11022 Philadelphia Road White Marsh, MD 21162

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Hilltop Service Corp. Date: 8/2/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Gregory E Reed

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	MYOCARDIAL INFARCTION	1 DAY
Due to (or as a consequance of): b.	CORONARY ARTERY DISEASE	5 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	HYPERTENSION	20 YEARS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

SLEEP APNEA SYNDROME

OBESITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D33407

29d. Date signed (Month, Day, Year): 7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEEPAK SETH 201 WISE AVENUE DUNDALK MD 21222

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen L. Kinstler

2. Date of Death: Month JULY Day 25 Year 2001

3. Time of Death: 2315

4e. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-22-8214

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/01/1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Bernie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 403 West Ordance Road

10f. Zip Code: 21061

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Joseph William Wunder

18. Mother's Name (First, Middle, Maiden Surneme): Helen Esslinger

19e. Informant's Neme/Reletionship (Type, Print): Lynn Kinstler / Daughter

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 176 Valley Street, Romney, West Virginia, 26757

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Meadowridge Memorial Park

Dete: 07/30/00

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Michele N Vehula M01241

22. Neme end Address of Fecility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229.

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

e. POST OPEN HEART SURGERY — 45 minutes

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

b. AORTIC STENOSIS — 3 years

Due to (or es e consequence of):

c. CORONARY ARTERY DISEASE — 13 years

Due to (or es e consequenca of):

d.

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es steted. 2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ F. Najam

29c. License number: MD 32257

29d. Date signed (Month, Dey, Year): 7/25/01

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): F. NAJAM MD UNION MEMORIAL HOSPITAL BALTIMORE MD

State Registrar

31. Dete filed (Month, Dey, Year): JUL 31 2001

32. Registrer's Signeture: ▶ Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death:
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24033

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LARRY D. LEWIS
2. Date of Death — Month: JULY Day: 29 Year: 2001
3. Time of Death: 12 05 AM
4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-60-2546
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 07/24/1952
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7200 Oakhaven Circle Apt. 304
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementery/Secondery (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter
16b. Kind of Business/Industry: Home Improvement

17. Father's Name *(First, Middle, Last)*: Henry Stuckey
18. Mother's Name *(First, Middle, Maiden Surname)*: Georgianna Lewis

19a. Informant's Name/Relationship *(Type, Print)*: Georgianna Manson / Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13 King James Circle, Baltimore, Maryland 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Mt. Zion Cemetery — Date: 08/03/01
20c. Location - City or Town, State: Landsdowne, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: The Derrick C. Jones F/H,P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PERITONITIS
Due to (or as a consequence of):
b. CHRONIC RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCITES, COPD, HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] C. Navi MD
29c. License number: D37333
29d. Date signed *(Month, Day, Year)*: JULY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. NAVI MD, NHC, ALTO. MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 31 2001
32. Registrar's Signature: [signature] G. Sparks

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24034

LINTHICUM, LOUISE 7.23.01 9:47PM
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last): LOUISE ELLEN ROOP LINTHICUM, Ph.D.

2. Date of Death (Month, Day, Year): July 23, 2001

3. Time of Death: 9:47 PM

4a. Facility Name (If not institution, give street and number): HOSPICE OF BALTIMORE AT GILCHRIST CENTER

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore County

5. Social Security Number: 723-14-7599

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Yaar: Months / Deys | If Undar 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 14, 1926

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedant

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 615 Chestnut Avenue

10f. Zip Code: 21204

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Decedent Evar in U.S. Armad Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondery (0-12): | Collega (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor

16b. Kind of Business/Industry: University of MD School of Nursing

17. Fathar's Nama (First, Middle, Last): Quentin Warren Roop

18. Mother's Nama (First, Middle, Maiden Surname): Mary Louise Williams

19a. Informent's Name/Reletionship (Type, Print): Mrs. Priscilla L. Graven (Dghtr)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 19 Regester Avenue, Baltimore, Maryland 21212

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Green Mount Crematory

Date: 7/25/2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name end Addrass of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use es the buriel-transit ecte.

5 Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eech line.

Approximata Intervel Between Onsat end Death

Immediate Causa (Finel disease or condition resulting in deeth): a. multiple cerebral infarctions — years

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immedieta cause. Enter Underlying Cause (Disease or Injury that Initieted avents resulting in death) Last:

b. Due to (or es e consequence of):

c. Dua to (or as e consequence of):

d.

Part II. **Other signiticant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Diabetes mellitus

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings availabla prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was case referred to medical exeminar? 1☐ Yas 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar (Specify) Hospice

27. Mennar of Deeth: 1☒ Naturel 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, data and place, and due to tha ceusa(s) and mennar es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data and place, and due to tha causa(s) and menner steted.

29b. Signature and title of certifier: Anthony Riley, MD

29c. Licensa number: D25205

29d. Data signad (Month, Day, Year): July 24, 2001

50

30. Nema and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley MD 6781 N. Charles St. Balto. md 21204

State Registrar

31. Data filed (Month, Dey, Year): JUL 31 2001

32. Registrar's Signeture: Geneva D Sparks

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24035

Physician /Medical Examiner

1. Dacedant's Name *(First, Middla, Last)*: Roberta D Lafayette
2. Data of Daath — Month: July; Day: 29; Yaar: 01
3. Tima of Death: 2:40pm
4a. Facility Nama *(If not institution, giva street and number)*: Copper Ridge
4b. City, Town, or Location of Daath: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-30-3025
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 81 Yrs.
If Undar 1 Yaar: Months; Days
If Undar 24 Hrs.: Hours; Min.
8. Data of Birth *(Month, Day, Yaar)*: May 26, 1919
9. Birthplace *(State or Foreign Country)*: New Hampshire

Usual Rasidance of Decedant

10a. Stata: Maryland
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 710 Obrecht Road
10f. Zip Coda: 21784
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada compiatad)*: Elamantary/Secondary (0-12); Collaga (1-4or 5+): 2
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Personel Manager
16b. Kind of Businass/Industry: Retail Sales

17. Fathar's Nama *(First, Middla, Last)*: unk
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: unk

19a. Informant's Name/Ralationship *(Type, Print)*: C.L.Lafayette II Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 2270 Duvall Road Woodbine Md. 21797

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Greenmount Cemetery
Data: 7/31/01
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funeral Service Licensee: Ernestine Wright
22. Nama and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach line.

Approximata Intarval Between Onsat and Death

Immediate Causa (Final disaasa or condition rasulting in death): a. Chronic Interstitial Lung Disease — Months

Due to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last:
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☒ No

25. Wes casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and titla of cartifiar: Ernestine Wright, MD
29c. Licansa number: D52740
29d. Data signad *(Month, Day, Year)*: July 30th, 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Ernestine Wright, CopperRidge, 710 Obrecht Road, Sykesville MD 21784

State Registrar

31. Data filad *(Month, Day, Year)*: JUL 31 2001
32. Registrar's Signatura: Geneva D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5
12

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CPM
01-4226-027
ELISHA LITTLETON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 080901:ITEMS#23a,27,28a-f per ME G798 ss **Certificate of Death**

Reg. No. 2001 24036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elisha Shavonne Littleton
2. Date of Death Month: JULY Day: 26, Year: 2001
3. Time of Death: 15:36
4a. Facility Name (If not institution, give street and number): 7900 block of Oceano Avenue
4b. City, Town, or Location of Death: Jessup
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-15-1068
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 26, 1980
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Brooklyn
10d. Inside City Limits: 1☐Yes 2☒No
10a. Street and Number: 4219 Doris Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Thomas J. Littleton
18. Mother's Name (First, Middle, Maiden Surname): Linda Marsiglia

19a. Informant's Name/Relationship (Type, Print): Thomas J. Littleton/ Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13893 Collins School Road, Felton PA 17322

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: July 28, 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings availabla prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year): 7-26-01
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found: off roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7900 block Oceano Ave. Jessup, Howard County, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. Licensa number: O.C.M.E.
29d. Date signed (Month, Day, Year): JULY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie Audrey Lample

2. Date of Death: Month July Day 28 Year 2001

3. Time of Death: 7:20 am

4a. Facility Name (If not institution, give street and number): Catonsville Commons

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-16-5898

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 9 1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 500 Virginia Avenue

10f. Zip Code: 21286

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookbinder

16b. Kind of Business/Industry: Publishing

17. Fether's Neme (First, Middle, Last): Samuel Holmes

18. Mother's Neme (First, Middle, Maiden Surneme): Grace Coleman

19a. Intormant's Neme/Relationship (Type, Print): Walter Lample/brother-in-law

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6109 Frederick Road, Baltimore, Maryland 21228

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other place): Loudon Park Cemetery

Dete: 8/2/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee ▶

22. Neme and Address of Fecility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deth. Do not enter the mode ot dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. ASCVD — Yrs

Due to (or es e consequenca ot): Paroxysmal Atrial fibrillation — Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy tindings evellable prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece ot Injury - At home, term, street, tactory, office building, etc. (Specify)

28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end dua to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier ▶ B. TURAKHIA Attending MD

29c. License number: D36942

29d. Date signed (Month, Day, Year): July 30, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): B. TURAKHIA, MD 1009, Frederick Rd. Baltimore, MD 21228

State Registrar

31. Dete filed (Month, Day, Year): JUL 31 2001

32. Registrer's Signeture: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUSSELL LEWIS

2. Date of Death: Month July Day 25 Year 2001

3. Time of Death: 12:33PM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 212 16 0555

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/15/20

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1102 DRUID HILL AVE. (APT1007)

10f. Zip Code: 21201

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. AFRO Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12 | College (1-4or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SKILL LABORER

16b. Kind of Business/Industry: UNITED IRON & METAL CO.

17. Father's Name (First, Middle, Last): WILLIE G. LEWIS

18. Mother's Name (First, Middle, Maiden Surname): FRANCES C LEWIS

19a. Informent's Name/Relationship (Type, Print): RUSSELL S. LEWIS SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 716 NEWINGTON AVE. BALTO. MD. 21217

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): METRO CREMATORY

Date: 7/27/01

20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signature of Funeral Service Licensee: CECIL A. ESTEP Cecil A Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL SER. P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory erresl, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death)

e. End Stage Liver Disease

Due to (or es a consequenca of):

Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. Coagulopathy

Due to (or es e consequenca of):

c. Hepatic Encephalopathy

Dua to (or es a consequence of):

d. GASTROintestinal Bleed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure

Acute Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S Ashruf MD

29c. License number: 89393

29d. Date signed (Month, Day, Year): 07-25-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. UMRAN ASHRUF M.D. C/O Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Russell Lewis
Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret W. Miller
2. Date of Death: Month July, Day 28, Year 2001
3. Time of Death: 5:20 PM
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 108-18-1136
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): SEPT. 08, 1914
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3710 CHESHOLM ROAD
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): ANITA ROBINSON (GRAND-DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3710 CHESHOLM ROAD, BALTIMORE, MD. 21216

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CEDAR HILL CEMETERY
Date: 08-01-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure
Due to, or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Sepsis
Due to, or as a consequence of):
c. Aspiration pneumonia
Due to, or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month, Day, Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD #284
29c. License number: P13594
29d. Date signed (Month, Day, Year): July 29 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George McGreevy
2. Date of Death (Month, Day, Year): July 17 2001
3. Time of Death: 1:00 a.m.
4e. Facility Name (If not institution, give street and number): 166 Sanford Avenue
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-24-5227
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 18, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 166 Sanford Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elevator Operator
16b. Kind of Business/Industry: City of Baltimore

17. Father's Name (First, Middle, Last): George Lewis McGreevy
18. Mother's Name (First, Middle, Maiden Surname): Alma de Chantel

19e. Informant's Name/Relationship (Type, Print): Mary McCaffrey Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4296 Mount Herbert Ave. San Diego CA, 92117

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto. Wash. Crematory
Date: 07/30/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Edison M. Perkins
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE MYOCARDIAL INFARCTION — 10 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY HEART DISEASE — 10 years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D36373
29d. Date signed (Month, Day, Year): 7/19/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARTIN A. ALBORNOZ 3449 Wilkens Ave #300 BALTIMORE 2229

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Mr. Sherry, George

2

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24041

Physician /Medical Examiner

1. Decedent's Nama (First, Middla, Last): Anthony Craig Marshall
2. Data of Deeth: Month July Day 28 Year 2001
3. Tima of Death: 8 30 AM
4a Facility Nama (If not institution, giva street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Sacurity Number: 214-96-1449
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct. 4, 1963
9. Birthplace (Stata or Foraign Country): Maryland

Usual Rasidance of Decedant

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 ☒ Yas 2 ☐ No
10e. Street and Number: 716 Arlington Ave Apt 2
10f. Zip Coda: 21217
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedant Evar in U.S. Armad Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yas 2 ☒ No Specify:
14. Race - Amaricen Indian, Black, Whita, atc. Specify: Black

15. Decedant's Education (Specify only highest grada completed): Elamantary/Secondary (0-12): 7 / Collega (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Maintenance man
16b. Kind of Businass/Industry: Nursing Home

17. Fether's Nama (First, Middla, Last): Howard Marshall, Sr.
18. Mothar's Nama (First, Middla, Maidan Surnama): Mable Cole

19a. Intormant's Name/Ralationship (Type, Print): Mable Cole / mother
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 125 Cherry Lane., Glen Burnie, MD 21060

20a. Mathod of Disposition: 1 ☐ Burial 2 ☒ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Chesapeake Crematory Inc
Data: 7/31/01
20c. Location - City or Town, Stata: Beltsville, MD

21. Signature of Funaral Service Licensee: ▶ [signature] M00784
22. Nama and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complicatlons that ceused tha daath. Do not enter the moda of dying, such es cardiac or raspiratory arrast, shock, or haart tailura. List only ona causa on aach lina.

Approximete Intarval Batwaan Onset and Death

Immedieta Causa (Final disaasa or condition resulting in daath):
a. Kaposi Sarcoma
Dua to (or as a consaquence of):
b. End Stage Acquired Immno defecienay Syndrome

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated avants resulting in death) Last:
Dua to (or as a consequance of):
c.
Dua to (or as e consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☐ No
24b. Wara autopsy tindings available prior to complation of cause of daath? 1 ☐ Yas 2 ☐ No

25. Was cesa ratarred to medical examinar? 1 ☐ Yas 2 ☐ No

26. Placa of Daath (Check only ona): STELLA MARIS AT MERCY
Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA
Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) HOSPICE

27. Mannar of Death: 1 ☐ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, tactory, office building, atc. (Specify)
28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1 ☐ **Certifying Physician:** To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and menner stated.

29b. Signature and titla of cartifiar: ▶ [signature]
29c. Licansa number: D40854
29d. Data signed (Month, Day, Year): July 30, 2001

30. Nama and addrass of person who completed ceusa of daath (Item 23e) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Data filed (Month, Day, Year): JUL 3 1 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-t show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth A. Melvin
2. Date of Death (Month, Day, Year): July 26, 2001
3. Time of Death: 10:43 AM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-58-7549
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 20, 1952
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 3427 Pleasant Place
10f. Zip Code: 21211
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Warren Connors
18. Mother's Name (First, Middle, Maiden Surname): Anna UNK.

19a. Informant's Name/Relationship (Type, Print): Christine Marie Melvin/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 Bellanca Court Middle River, MD 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 7-27-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Esophageal Cancer
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Stella Maris at Mercy Hospice
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dr. Ryan
29c. License number: D40854
29d. Date signed (Month, Day, Year): July 26, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Orra V. Miller-Gonzalez
2. Date of Death (Month, Day, Year): July 30, 2001
3. Time of Death: 6:40 AM

4a. Facility Name (If not institution, give street and number): Ruxton Health & Rehab. Center
4b. City, Town, or Location of Death: Pikesville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 490-18-1688
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 17, 1904
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 403 West Ordnance Road
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): UNK. Waters
18. Mother's Name (First, Middle, Maiden Sumeme): Martha UNK.

19a. Informant's Neme/Relationship (Type, Print): Martha Long/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6410 Kriel Street Baltimore, MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 7-30-01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Acute Stroke
Due to (or as a consequence of):
b. Acute Septicemia

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury thet Initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Failure to thrive
Chronic Debilitating Pain

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or Investigation, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: Edward Sleeman MD
29c. License number: D19171
29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Edward Sleeman MD 4000 old Court Road Pikesville, Maryland 21208

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Donna D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24044

Henry Morris's

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Henry G. Morris		2. Date of Death (Month, Day, Year): July 27 2001	3. Time of Death: 2:50 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital	4b. City, Town, or Location of Death: Rosedale	4c. County of Death: Baltimore	
5. Social Security Number: 220-01-5506	6. Sex: 1☒M 2☐F	7. Age (If yrs. last birthday): 86 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): May 1,1915	9. Birthplece (State or Foreign Country): Georgia		
Usuel Residence of Decedent			
10a. State: Maryland	10b. County: n/a	10c. City, Town or Location: Baltimore City	10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3716 Foster Avenue	10f. Zip Code: 21224	10g. Citizen of Whet Country?: United States	
11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 Years; College (1-4or 5+):	16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver	16b. Kind of Business/Industry: Maryland Transit Authority	
17. Father's Neme (First, Middle, Last): Ernest Morris	18. Mother's Name (First, Middle, Meiden Surneme): Mabel Jenkins		
19e. Informant's Name/Relationship (Type, Print): Mrs. Dorothy B. Morris (Wife)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3716 Foster Avenue Baltimore, Maryland 21222		
20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other piece): Oak Lawn Cemetery	Date: 7/31/2001	20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Stephanie Massey	22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Septic Shock — 1 Day

Due to (or as a consequence of):
b. Over Whelming Clostridium Difficile — 3 DAYS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last
Due to (or as e consequence of):
c.

Due to (or as e consequenca of):
d.

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year
Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.	23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown	
	24a. Was en autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)		
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury M	28c. Injury et Work? 1☐Yes 2☐No
	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number: D37612	29d. Date signed (Month, Dey, Yeer): July 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Mohamad Alabrash 9008 Franklin Square Dr. Baltimore Md 21237

State Registrar

31. Date filed (Month, Day, Yeer): JUL 31 2001

32. Registrar's Signature:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24045

AMND ITM#8 pPR. F.H. G797 7-31-01 JB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THEODORE MILLMAN
2. Data of Death Month: JULY Day: 26 Year: 2001
3. Time of Death: 8:30PM
4a. Facility Name (If not institution, give street and number): HOSPICE OF BALTIMORE-GILCHRIST CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 194-18-4058
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): ~~SEPT 9~~ SEPT. 19 1923
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: OWINGS MILLS
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 8002 TOWNSHIP DRIVE UNIT F
10f. Zip Coda: 21117
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN
16b. Kind of Business/Industry: ADVERTISING

17. Father's Name (First, Middle, Last): JOSEPH MILLMAN
18. Mother's Name (First, Middle, Maiden Surname): ROSE WOLOSKY

19a. Informant's Name/Relationship (Type, Print): MRS. ROSLYN MILLMAN/ WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8002 TOWNSHIP DRIVE UNIT F OWINGS MILLS, MD. 21117

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MONTEFIORE CEMETERY
Data: 7/29/01
20c. Location - City or Town, State: ABINGTON, PA.

21. Signature of Funeral Service Licensee: Scott M. Cuttler
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic adenocarcinoma of

Due to (or as a consequence of):
b. Undetermined primary site months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Hospice

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Timothy Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): July 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Benjamin D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8:30 P.M July 26 2001

Theodore Millman July 26 2001

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24046

MILLENBURG, HELEN 7.29.01 12:01 AM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN MILLENBURG
2. Date of Death (Month, Day, Year): JULY 29 2001
3. Time of Death: 1201 AM
4a. Facility Name (If not institution, give street and number): GILCREST HOSPICE
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-12-9581
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 15, 1919
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE Md
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2614 WINDSOR Rd
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: NAVY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+): —
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): COMPUTER OPER.
16b. Kind of Business/Industry: BGE

17. Father's Neme (First, Middle, Last): CLARENCE HAFE
18. Mother's Name (First, Middle, Maiden Surname): FLERENCE BELT

19a. Informent's Neme/Reletionship (Type, Print): THOMAS MILLENBURG
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2614 WINDSOR Rd. Balto Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEM — Date: 7/31/01
20c. Location - City or Town, State: Balt Md.

21. Signature of Funeral Service Licensee: ▶ Paul M Stella
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 HARFORD Rd. Balto Md. 21234

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Creutzfeldt-Jakob disense — 1 ½ yeers

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: ▶ W Anthony Riley, MD
29c. License number: D25005
29d. Date signed (Month, Day, Year): July 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrer's Signeture: ▶ D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 24047

Nash, Hilda

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
HILDA MAY TRACEY NASH	July 28, 2001	8:30pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Greater Baltimore Medical Center	Towson	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-58-5711	1☐M 2☒F	83 Yrs.			May 1, 1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Lutherville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1512 Riderwood-Lutherville Drive	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Homemaker	Own Residence

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Tracey	Delca Christina Howard

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles W. Nash (Son)	1040 Donington Circle, Towson, MD 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Poplar Grove U.M. Cem	7/31/2001	Phoenix, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Martin D. Lawson	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. Pulmonary Edema — 1wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. C. A. D (coronary artery disease) — 2 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D42736	7-29-01

30. Name and address of person who completed cause of death item 23a) (Type, Print)
670 N Charles Street Towson Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Jeanne P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Niall S. O'Doherty
CJ
01-4253-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Niall Seamus O'Doherty
2. Date of Death: Month July, Day 27, Yaar 2001
3. Time of Death: 04:15 P.M.
4a. Facility Name (If not institution, give street and number): Unit block West Hamburg Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-17-3078
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 20 Yrs. If Under 1 Year: Months, Days. If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): FEB 14, 1981
9. Birthplace (State or Foreign Country): Oregon

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 127 Lafayette Avenue
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Etementary/Secondery (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: N/A

17. Fathar's Nama (First, Middle, Last): Pearse O'Doherty
18. Mother's Name (First, Middle, Meiden Surname): Annice Fields

19a. Informant's Name/Reletionship (Type, Print): Pearse O'Doherty/Father
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 127 Lafayette Avenue Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or othar place): Metro Crematory Inc.
Date: 7-30-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funaral Service Licensaa: Thomas Gregor
22. Name and Addrass of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha death. Do not entar the moda of dying, such as cardiac or raspiratory arrest, shock, or heart teilure. List only one ceuse on each line. Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributa to the causs of death? 1 [ ] Yss 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? [X] Yas 2 [ ] No
24b. Were autopsy findings available prior to completion of causa of death? [X] Yes 2 [ ] No

25. Was case refarred to medical exeminer? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 7/27/01
28b. Time of Injury: 4:00 P. M
28c. Injury at Work? 1 [X] Yes 2 [ ] No
28d. Describe how injury occurred: Subject Fell From Construction Machine and Struck By Wheel
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): West Hamburg Street Baltimore, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 [X] **Medical Examiner:** On the besis of exeminetion and/or investigation, in my opinton, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner stated.
29b. Signatura and title of certifier: Joseph Pestaner, M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): July 28, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24049

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William P. Powell
2. Date of Death Month: July Day: 29 Year: 2001
3. Time of Death: 11:35
4a. Facility Neme (If not institution, give street end number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-26-7739
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 12-05-40
9. Birthplace (State or Foreign Country): MD

Usuat Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No XX
10e. Street and Number: 7086 McClean Blvd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No X If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No X Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: O.S.T. Trucking Co

17. Father's Neme (First, Middle, Last): Charles Powell
18. Mother's Name (First, Middle, Maiden Surname): Nettie Smith

19a. Informant's Name/Reletionship (Type, Print): Meritta L. Powell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 7086 McClean Blvd. Baltimore, Maryland 21234

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Woodlawn Cemetery | Dete: 08-03-01
20c. Location - City or Town, State: Woodlawn, MD

21. Signeture of Funeral Service Licensee: ▶ Gladys Warner
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Gastrointestinal tract Bleed	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last b.	Hypotension	1 day
Due to (or as a consequence of):		
c.		
Due to (or es a consequence of):		
d.		

Part II. **Other signifIcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dtd tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy tindings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Netural 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rure! Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner es stated. 2☐**Medicat Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Jonathan Hefner MD
29c. License number: MES 000
29d. Date signed (Month, Dey, Year): July 29 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JONATHAN HEFNER 3481 Belvedere Avenue Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: ▶ Dennis D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Powell, William Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Veronica Cecelia Pallo
2. Data of Deeth Month Day Yeer: July 28, 2001
3. Time of Death: 2:25 AM
4a Facility Nema (If not institution, give street and number): Genesis Heritage Meridian Eldercare Ctr.
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-28-3656
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Yaar: Months / Deys | If Undar 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): April 8,1914
9. Birthplaca (Stete or Foreign Country): Pennsylvania

Usuat Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 3317 McShane Way
10f. Zip Code: 21222
10g. Citizen of Whet Country?: United States
11. Maritel Status: 1☐ Nevar Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Ever in U,S. Armed Forces? 1☐ Yes 2☐ No If Yas, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 Years | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Packer
16b. Kind of Business/Industry: Lever Brothers Corp
17. Fether's Neme (First, Middle, Last): Michael Leagon
18. Mother's Neme (First, Middle, Maiden Surname): Anna Not Known
19a. Informant's Name/Reletionship (Type, Print): John C. Pallo, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13506 Castleway Road Middlothian, VA 23114
20e. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Oak Lawn Cemetery
Date: 7/31/2001
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Deagon E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
e. CONGESTIVE HEART FAILURE

Due to (or es a consequence of):
b. ATRIAL FIBRILLATION

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):
c. IMPETIGO

Due to (or as a consequence of):
d. MALNUTRITION

Pert II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveileble prior to completion of causa of death? 1☐ Yas 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and menner steted.

29b. Signature and titla of certifier: Savinder K Tukka
29c. License number: D17188
29d. Date signed (Month, Dey, Yeer): 7/30/01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): SAVINDER K TUKKA 2 MARKET PLACE BALT, MD 21222

State Registrar

31. Dete filed (Month, Day, Yeer): JUL 31 2001
32. Registrer's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24051

Pt known as: Shirley M. Patt

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY M. PATT

2. Date of Death: Month July, Day 28, Year 2001

3. Time of Death: 1414

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-0803

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): MAY 7 1922

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6106 WESTCLIFF DRIVE

10f. Zip Code: 21209

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SOCIAL WORKER

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): ISAAC BERMAN

18. Mother's Name (First, Middle, Maiden Surname): SARAH KATZ

19a. Informant's Name/Relationship (Type, Print): DR. HOWARD H. PATT/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6106 WESTCLIFF DRIVE BALTIMORE, MD. 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place): ARLINGTON CEMETERY CONGREGATION AMUNO

Date: 7/29/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Edward C. Russ

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary Edema — 1 wk

Due to (or as a consequence of):

b. Valvular Heart disease — >30 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequanca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Liver Failure, End stage

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): July 28, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stephen A. Williams, MD Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

ORIGINAL

HERMENIA PERRT
01-42740510
RDC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 24052
Reg. No.

UNPENDED 080801:ITEMS#23a,27,28a-f per ME G798 SS

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERMENIA E. PERRY

2. Data of Death Month: JULY Day: 29 Yaar: 2001

3. Time of Death: 0213AM

4a. Facility Name *(If not institution, give street and number)*: ST AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-88-2262

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 5-9-1963

9. Birthplace *(State or Foraign Country)*: MARYLAND

Usual Rasidance of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 414 N. LOUDON AVE.

10f. Zip Coda: 21229

10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): -12- Collega (1-4or 5+): -0-

16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: OPERATOR

16b. Kind of Busnass/Industry: TELEPHONE

17. Fathar's Nama *(First, Middla, Last)*: HERMAN PERRY

18. Mothar's Nama *(First, Middle, Maiden Surneme)*: BERTHA ROBINSON

19a. Informant's Name/Ralationship *(Type, Print)*: BERTHA PERRY (MOTHER)

19b. Mailing Addrass *(Straat and Number or Rural Route Number, City or Town, State, Zip Code)*: 414 N. LOUDON AVE. BALTIMORE, MARYLAND 21229

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, crematory or othar place)*: ARBUTUS MEMORIAL PARK

Data: 8-2-2001

20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signature of Funaral Service Licensee: Jonath D. Hizne

22. Nama and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. COCAINE AND NARCOTIC INTOXICATION

Dua to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No

24b. Ware autopsy findings available prior to compiation of causa of death? 1☒ Yas 2☐ No

25. Wes case rafarrad to medical examiner? 1☒ Yas 2☐ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury *(Month, Day Year)* found: 7-29-01

28b. Time of Injury: unknown M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Describe how injury occurred: Unknown

28a. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: residence

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*: 414 Loudon Ave., Balto., MD

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledge, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and manner stated.

29b. Signatura and title of certifiar: Theodore M. King MD

29c. Licansa number: OCME

29d. Data signed *(Month, Day, Year)*: JULY 29 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 31 2001

32. Registrar's Signatura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
WILLIAM	B.	ROWLEY	JULY 29 2001	9:15 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4216 KENSINGTON ROAD	Baltimore	Baltimore County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-40-1110	1 [X] M 2 [ ] F	58 Yrs.			June 12 1943	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore Co.	Baltimore	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4216 Kensington Road	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Police Officer	Baltimore City Police

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clyde J. Rowley	Betty Bonniwelle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anna L. Rowley (Wife)	4216 Kensington Road, Baltimore, Md. 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)	Glen Haven Memorial Pk.	8/02/2001	Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Thomas P. Polyniak

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of lung	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Emphysema	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [X] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular disease

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Baskaran	D21649	July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMANDAM BASKARAN 3455 WILKENS AVE BALTIMORE. MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Denise M Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Steven Todd Raley, Sr.

2. Date of Death (Month, Day, Year): July 30, 2001

3. Time of Death: 2:50 pm

4a. Facility Name (If not institution, give street and number): Gilchrist Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-80-8930

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 18, 1967

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7914 St. Gregory Drive

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker

16b. Kind of Business/Industry: General Motors Factory

17. Father's Name (First, Middle, Last): William Martin Raley

18. Mother's Name (First, Middle, Maiden Surname): Roberta Moorehead

19a. Informant's Name/Relationship (Type, Print): Ann Raley / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7914 St. Gregory Dr., Baltimore, MD 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc | Date: 8/1/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. SARCOMA — months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier: R Anthony Riley, MD

29c. License number: D25285

29d. Date signed (Month, Day, Year): July 30, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7/30/01 2:50PM

Steven Raley, Sr

10

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24055

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: ETHEL ROCHESTIE

2. Dete of Death (Month / Dey / Year): JULY 27 2001

3. Time of Death: 10:25AM

4e. Facility Neme *(If not institution, giva street and number)*: HOSPICE OF BALTIMORE- GILCHRIST CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 142-01-2468

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: JULY 13 1917

9. Birthplece *(State or Foreign Country)*: NC

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Stete: FL

10b. County: BROWARD

10c. City, Town or Location: COCONUT CREEK

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2201 LUCAYA BEND

10f. Zip Code: 33066

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Fathar's Name *(First, Middle, Last)*: MORRIS PERLITCH

18. Mother's Nama *(First, Middle, Maiden Surname)*: JENNY HEVESON

19a. Informent's Name/Reletionship *(Type, Print)*: MR. HOWARD ROCHESTIE/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 366 SHEFFIELD ROAD MONTECITO, CA.93108

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☒ Removal from Stata 4☐ Donetion 5☐ Othar *(Specify)*

20b. Plece of Disposition *(Nama of cemetery, crematory or other place)*: FOUNTAIN LAWN MEMORIAL PARK

Date: 7/ 29/01

20c. Location - City or Town, State: TRENTON, NJ.

21. Signature of Funeral Service Licensee: Scott M. Cuttler

22. Name end Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disaesa, or complications thet causad the daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Daath

Immediate Cause (Finel diseese or condition resulting in daath): e. Septicemia — 10 days

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediete causa. Entar Underlying Ceuse (Diseese or Injury that initiated avents resulting in deeth) Lest:

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: Supra sellar mass of undetermined etiology

Hypercalcemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings eveilable prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Mennar of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, streat, fectory, offica building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha tima, date and place, and dua to tha cause(s) end menner steted.

29b. Signetura end title of certifier: A. Anthony Riley, MD

29c. License number: D25205

29d. Data signed *(Month, Day, Year)*: July 27, 2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): W. A. Riley CBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 3 1 2001

32. Registrer's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ethel Rochestie July 27, 2001 @ 10:25 AM

1.8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 24056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Abe	Rosenbloom	July 26 2001	0510 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northwest Hospital Center	Randallstown	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-14-9218	1☒M 2☐F	82 Yrs.			JUNE 2 1919	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	RANDALLSTOWN	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3908 LAUSANNE ROAD	21133	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No WW II	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		OWNER	DRY GOODS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JACOB ROSENBLOOM	LENA HARRIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. MERLE ROSENBLOOM/WIFE	3908 LAUSANNE ROAD RANDALLSTOWN, MD. 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MIKRO KODESH BETH ISRAEL CONG.	7/29/2001	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Thomas	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Occipital stroke	days
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D Roggen MD	D 35844	July 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D Roggen 5401 Old Court Road Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#18 PR. F.H.G797 7-31 JB **Certificate of Death** Reg. No. 2001 24057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HELEN ROTHMAN	JULY 26, 2001	7:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-01-8531	1☐M 2☒F	84 Yrs.			FEB 7 1917	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
83 RIVER OAKS CIRCLE	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SALES PERSON	CLOTHING

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
HARRY COHEN	ROSE FABER ~~FARBER~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. HAROLD ROTHMAN/ SON	83 RIVER OAKS CIRCLE BALTIMORE, MD. 21208

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BETH TFILOH CONG.	7/29/2001	WOODLAWN, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Scott M. Cuthlin	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOKALEMIA

Due to (or as a consequence of):
b. DEHYDRATION

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	

Part It. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIN
H/O Toxic Encephalopathy
H/O V. FIBRILLATION ARREST

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause ot death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
MD	D 51245	JULY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAJID SHAKIF NORTHWEST HOSPITAL - Randallstown - MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

HELEN ROTHMAN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WEBSTER CARL RICHARDS

2. Date of Death (Month, Day, Year): July 25, 2001

3. Time of Death: 7:34 A.M.

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-05-9538

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 26, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8919-A Waltham Woods Road

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Licenced Tree Expert

16b. Kind of Business/Industry: Horticulture

17. Father's Name (First, Middle, Last): Webster Cox Richards

18. Mother's Name (First, Middle, Maiden Surname): Edith Grace Sindall

19a. Informant's Name/Relationship (Type, Print): Webster Carl Richards, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4610 Schenley Road Baltimore, Maryland 21210

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 7-28-01

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: George J. Ferrare

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic prostate cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): July 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley Gomez 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Richards, W. Carl 7/25/01 7:34am

3

01-4218-510
CHRISTOPHER SMITH
ASP
UNK 01-189

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHRISTOPHER SMITH JR.
2. Date of Death: Month JULY Day 25 Year 2001
3. Time of Death: 2245
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-04-5767
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 17 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 06, 1983
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 225 NORTH CAREY ST.
10f. Zip Code: 21223
10g. Citizen of What Country? USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: HIGH SCHOOL

17. Father's Name (First, Middle, Last): CHRISTOPHER SMITH SR.
18. Mother's Name (First, Middle, Maiden Surname): VALERIE LOCKWOOD

19a. Informant's Name/Relationship (Type, Print): VALERIE COOPER (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2808 WOODBROOK AVE., BALTO, MD. 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 7-31-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Ruth N. Wall
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gunshot Wound to Chest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 7/25/01
28b. Time of Injury: 2223 HRS
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1600 Block East Madison Baltimore Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. King
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JULY 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: P. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24060

SAKOWICH, William
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William John Sakowich
2. Date of Death (Month, Day, Year): July 28, 2001
3. Time of Death: 10:01 P.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE Hospital Center
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 056 22 9109
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 20, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 315 Bowleys Quarters Rd.
10f. Zip Code: 21220
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Manager
16b. Kind of Business/Industry: Motor Truck Equipment

17. Father's Name (First, Middle, Last): George Sakowich
18. Mother's Name (First, Middle, Maiden Surname): Anna Korneluk

19a. Informant's Name/Relationship (Type, Print): Shirley Sakowich (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 315 Bowleys Quarters Rd. Baltimore, Md. 21220

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 8/3/2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ John W. Burkowske MO1091
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final diseese or condition resulting in death)
a. ANOXIC BRAIN INJURY
Due to (or es e consequence of):
b. Asystole
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were sutopsy findings available prior to completion of cause of death? 1 ☐ Yaa 2 ☐ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigetion, In my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and mannar statad.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: RD 207613
29d. Date signed (Month, Day, Year): July 28, 2001
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Ashok Ambadekar, M.D. - 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MARYLAND 21237

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24061

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAROLD STALNAKER
2. Date of Death Month / Day / Year: July 26, 2001
3. Time of Death: 5:17 PM
4a. Facility Name *(If not institution, give street and number)*: Harbor Hospital Center 3001 So. Hanover St
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 233-50-3997
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 9, 1933
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: [X] 1 Yes 2 [ ] No
10e. Street and Number: 1441 Richardson Street
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Army 52-55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Longshoreman
18b. Kind of Business/Industry: Shipping

17. Father's Name *(First, Middle, Last)*: Clarence Stalnaker
18. Mother's Name *(First, Middle, Maiden Surname)*: Genevieve Eye

19a. Informant's Name/Relationship *(Type, Print)*: Shirley Stalnaker / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1441 Richardson Street, Baltimore Maryland 21230

20a. Method of Disposition: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Veterans Cem.
Date: July 30, 2001
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):
b. ASHCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: H0055706
29d. Date signed *(Month, Day, Year)*: July 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michelle Duchneskie DO 3001 Hanover St. Balto. MD 21230

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 31 2001
32. Registrar's Signature: Penina D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE T. SMITH

2. Date of Death (Month, Day, Year): July 29, 2001

3. Time of Death: 6 35 AM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 705-10-9357

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 27 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 135 E. Ostend Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Arundel Corp.

17. Father's Name (First, Middle, Last): John C. Smith

18. Mother's Name (First, Middle, Maiden Surname): Clara Obrecht

19a. Informant's Name/Relationship (Type, Print): Mary E. Smith (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 135 E. Ostend Street, Baltimore, Md. 21230

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 8/02/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: McCully-Polyniak Funeral home P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Panoytopenia of unknown etiology

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Stella Maris at Mercy

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: D 40854

29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Shaw

2. Date of Death: Month Jul Day 29 Year 2001

3. Time of Death: 9:19pm

4e. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-6731

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-10-1929

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2006 ROBB STREET

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHEET METAL MECHANIC

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): LEO SHAW

18. Mother's Name (First, Middle, Maiden Surname): LUCY TAYLOR

19a. Informant's Name/Relationship (Type, Print): NOVELLA SHAW, WIFE

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2006 ROBB STREET, BALTO. MD 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 7-31-01

20c. Location - City or Town, State: OWING MILLS, MD

21. Signature of Funeral Service Licensee: ▶ Howell

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. myocardial infarction — 4 days

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: metastatic carcinoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Mobasheri Medical Resident

29c. License number: P13396

29d. Date signed (Month, Day, Year): 7/29/2001 / July 29, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NILOUFAR MOBASHERI Department of Medicine 22 S. Greene Street, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Elwood Shockley
2. Date of Death: Month July, Day 20, Year 2001
3. Time of Death: 0110 Am
4a. Facility Name (If not institution, give street and number): Joseph Richie Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-40-4037
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 19, 1942
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 912 Park Avenue #120
10f. Zip Code: 20707
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Broker
16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Sylvester E. Shockley
18. Mother's Name (First, Middle, Maiden Surname): Marie Hobbs

19a. Informant's Name/Relationship (Type, Print): Shelby Wilkins
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 218 Long Avenue Salisbury, MD 21801

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation
Date: 7/20/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ B. O
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave Laurel MD 20707

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

12:55 AM

7/20/01

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Colorectal carcinoma — 2½ yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify): Hospice
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Richard Shockley 7/20/01

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Julia A. Haller MD
29c. License number: D32600
29d. Date signed (Month, Day, Year): 7/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julia A. Haller 600 N. Wolfe St. Balto 21287

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine M. Stettler

2. Date of Death: Month July, Day 26, Year 2001

3. Time of Death: 9:45 AM

4a. Facility Name (If not institution, give street and number): Sunrise Assited Living

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 360-38-5266

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 24 1908

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 715 Maiden Choice Lane CC 507

10f. Zip Code: 21228

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Marwitz

18. Mother's Name (First, Middle, Maiden Surname): Bertha Beck

19a. Informant's Name/Relationship (Type, Print): Dr. H. Louis Stettler,III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 675 Genessee Street, Annapolis, Maryland 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: 7/26/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Breast Cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) assisted living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D-50725

29d. Date signed (Month, Day, Year): 7/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jennifer Riedinger MD 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanor Mary Siegmann

2. Date of Death: Month July Day 29 Year 2001

3. Time of Death: 2:00 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-60-9558

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05/19/1915

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: N/A

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3300 Benson Ave. APT 428

10f. Zip Code: 21227

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Robert Albiker

18. Mother's Name (First, Middle, Maiden Surname): Margaret Maizel

19a. Informant's Name/Relationship (Type, Print): Patricia Gurbelski / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3616 Benson Ave. Baltimore, MD 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park

Date: 08/01/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Bernard Gurbelski

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic obstructive pulmonary disease — 40 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Thompson M.D. (resident)

29c. License number: P14447

29d. Date signed (Month, Day, Year): July 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): St. Agnes Hospital 900 Caton Ave. Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Siegmann, Eleanor

6

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-4280-510

MAHALINGA SUBRAMANIAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mahalingam Subramanian
2. Date of Death (Month, Day, Year): JULY 28, 2001
3. Time of Death: 7:00P.M.
4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 371-08-9910
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 35 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 3, 1966
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: NJ
10b. County: Morris
10c. City, Town or Location: Parsippany
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 77 Farmingdale Rd
10f. Zip Code: 07054
10g. Citizen of What Country?: India

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Engineer
16b. Kind of Business/Industry: Technology

17. Father's Name (First, Middle, Last): Subramanian Vaidvanathan
18. Mother's Name (First, Middle, Maiden Surname): Sundaravalli Subramanian

19a. Informant's Name/Relationship (Type, Print): Vaidyanathan Subramanian / brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2055 Baron Dr., Rochester Hills, MI 48307

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc
Date: 8/4/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. MULTIPLE INJURIES COMPLICATED BY DROWNING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 7/24/01
28b. Time of Injury: 1205 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT JUMPED OFF OF BRIDGE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): BAY BRIDGE
28f. Location (Street and Number or Rural Route Number, City or Town, State): US 50/301 EAST BOUND BAY BRIDGE, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JULY 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Peter Shusta
2. Date of Death: Month July Day 25, Year 2001
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): Genesis Cromwell Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 152-05-6616
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 1,1908
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2825 Lodge Farm Road Apt. 318
10f. Zip Code: 21219
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6 Years | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Bakery Superintendent
16b. Kind of Business/Industry: A & P Food Company

17. Father's Name (First, Middle, Last): Dominick Shusta
18. Mother's Name (First, Middle, Maiden Surname): Agnes Nowak

19a. Informent's Neme/Reletionship (Type, Print): Ronald D. Shusta (Son)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3008 Acton Road Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Gardens of Faith Cemetery
Dete: 7/31/2001
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failura. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Gastrointestinal Bleeding

Dua to (or es a consequanca of): b. Anemia

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last

Due to (or es e consequence of): c. Abdominal Aortic Aneurysm

Due to (or es e consequence of): d. Renal Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Sepsis, Deep Venous Thrombosis Dementia

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yss 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D57543
29d. Date signed (Month, Dey, Year): 07/27/2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Preetinder Sandhu M.D., 3007 E Northern Parkway 21214

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24069

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gertrude M. Smith	July 26, 2001	9:02 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FutureCare Canton Harbor Ctr.	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-32-0430	1☐ M 2☒ F	96 Yrs.			Sept. 11, 1904	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
111 Woodland Avenue	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12 Years		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Christopher Muth	Wilhelmina Landau

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth Miller (Niece)	3123 Vulcan Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parkwood Cemetery	7/30/2001	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE PULMONARY EMBOLISM	MINUTES
Due to (or as a consequence of): b.	INTRAVASCULAR DEHYDRATION	3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last: Due to (or as a consequence of): c.	ADVANCED CACHEXIA	2 MONTHS
Due to (or as a consequence of): d.	TERMINAL CARCINOMA OF COLON	16 MONTHS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph D. Notarangelo M.D.	D07316	JULY-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH D. NOTARANGELO, M.D. 391 ST. PAUL PLACE BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24070

AMENDITEM #22 OER FH G797 7/31/01 JH

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): GLENNA M. STAEHLIN

2. Dete of Deeth: Month JULY Dey 26 Yeer 2001

3. Time of Death: 11:30 PM

4e. Fecility Name (If not institution, giva street and number): MARINER HEALTH-OVERLEA

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Deeth: BALTIMORE CITY

Funeral Director

5. Socie! Security Number: 214-26-7503

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Sept.29,1928

9. Birthpleca (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 115 Linhigh Avenue

10f. Zip Code: 21236

10g. Citizen of Whet Country?: USA

11. Maritat Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12): 12th grade

College (1-4or 5+): N/A

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Housekeeping-Own Home

17. Fether's Neme (First, Middle, Last): Glennyn Nash

18. Mother's Neme (First, Middle, Maiden Sumeme): Maxine Gans

19e. Informent's Name/Reletionship (Type, Print): Gary P. Staehlin (Son)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 Linhigh Avenue Baltimore, Maryland 21236

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Pleca of Disposition (Nema of cemetery, cremetory or other piece): Metro Crematory Inc.

Dete: 7-30-01

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funeral Service Licensea: E. J. Lassahn

22. Name and Address of Facility: Lassahn Funeral ~~Hom.~~ HOME 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter tha disease or complications that caused tha daath. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. CEREBROVASCULAR ACCIDENT — 10 YEARS

Dua to (or es a consequanca of): b. HYPERTENSION

Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last

Due to (or es a consequence of): c.

Dua to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performad? 1☐ Yas 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Coutd not be determined

28e. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end mannar stated.

29b. Signeture and title of certifier: Luis Rivera

29c. License number: D083494

29d. Date signed (Month, Day, Year): 7/27/01

30. Nama end address of person who completed cause of deeth (Item 23e) (Type, Print): Luis Rivera, M. D. 5714 Harford Rd. Baltimore, Md. 21214

State Registrar

31. Dete filed (Month, Day, Yeer): JUL 31 2001

32. Registrar's Signature: Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24071

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN L. SWARM JR.

2. Date of Death — Month: JULY Day: 26TH Year: 2001

3. Time of Death: 17:35

4a. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-68-0618

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 31 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04/22/1970

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 906 WEST UNIVERSITY PARKWAY

10f. Zip Code: 21210

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2YRS

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: APPRAISER

16b. Kind of Business/Industry: APPRAISALS

17. Father's Name *(First, Middle, Last)*: JOHN L. SWARM

18. Mother's Name *(First, Middle, Maiden Surname)*: CARROLL HUDSON

19a. Informant's Name/Relationship *(Type, Print)*: MRS. CARROLL SWARM(MOTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10807 LINSON RD. OWINGS MILLS,MD. 21117.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. THOMAS GARRISON

Date: 07/30/2001

20c. Location - City or Town, State: OWINGS MILLS,MD.

21. Signature of Funeral Service Licensee: William C. Sparks III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — One day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Hennawi, MD

29c. License number: AT2438946

29d. Date signed *(Month, Day, Year)*: July 26TH 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Hennawi, UMH 201 E. University Pkwy. Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 31 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24072

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard T. Slater

2. Date of Death — Month: JULY Day: 26th Year: 2001

3. Time of Death: 7:39 PM

4e. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-52-6349

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 28, 1949

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Balimore City

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 524 North Ellwood Avenue

10f. Zip Code: 21205

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: '70-'72

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: Telemarketing

17. Father's Name *(First, Middle, Last)*: Charles E. Slater

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Radies

19a. Informant's Name/Relationship *(Type, Print)*: Teresa D. Slater - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 524 N. Ellwood Avenue Baltimore, Maryland 21205

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore-Washington Crematory — Date: 7-28-01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Elizabeth Selenke

22. Name and Address of Facility: Moran-AShton-Matthew Funeral Home, INc. 3000 E. Baltimore St. Baltimore, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final diseesa or condition resulting in death)
a. SEPSIS — 2 days
Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last
b.
Due to (or as a consequanca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ESRD, Dilated Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)* — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Panding investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)* 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Hennawi, MD

29c. License number: AT2438946

29d. Date signed *(Month, Day, Year)*: July 26th 2001

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: George Hennawi, MD UMH 201 E. University Pkwy, Baltimore MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 31 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Joseph TURNER	July 29 2001	4:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-30-3594	1☑M 2☐F	65 Yrs.			4-22-36	St. Mary's Co MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6247 Gilston Pk. Rd	21228	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th GR	0	BAKER	BAKERY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SHEDRACH TURNER	EVELYN PARKER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARITA WYNN	6247 GILSTON Park Rd Catonsville MD.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State 21228
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ARBUTUS	8/2/01	Baltimore

21. Signature of Funeral Service Licensee: Brian L. Miller

22. Name and Address of Facility

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Prostate Cancer — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD.	P13594	July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
St. Agnes Hospital, 900 Caton Ave, Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Joseph Turner

RR

RL 2

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Lee Travers
2. Date of Death (Month, Day, Year): July 29, 2001
3. Time of Death: 10:30 AM
4e. Facility Name (If not institution, give street and number): 1710 Landmark Drive #L
4b. City, Town, or Location of Death: Forest Hill
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 202-26-7391
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 1, 1936
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1710 Landmark Drive #L
10f. Zip Code: 21050
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Antiques
16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Samuel James Patterson
18. Mother's Name (First, Middle, Maiden Surname): Clara Barton King

19a. Informant's Name/Relationship (Type, Print): Shannon Travers/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Glenview Terrace Abingdon, MD 21109

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 7-30-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SMALL CELL LUNG CANCER — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: John P. Edwards M.D.
29c. License number: D31775
29d. Date signed (Month, Day, Year): JULY 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOAN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SOPHIA TKATCH

2. Date of Death Month: July Day: 28 Year: 2001

3. Time of Death: 12:48 P M

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 168-14-7243

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 4, 1922

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3477 McShane Way

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest greda completed)

Elementary/Secondary (0-12): 12 Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Administrative Clerical

16b. Kind of Businass/Industry: Banking

17. Father's Nama (First, Middle, Last): Felix Lockman

18. Mother's Name (First, Middla, Maidan Surnema): Sophia Balakier

19a. Informant's Name/Relationship (Type, Print): Susan Rosenthal (Daughter)

19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda): 855 Oakleigh Beach Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Baltimore National Cem. Date: 7/31/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complicetions that caused tha deeth. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or hepa failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. LUNG CANCER — Approximate Interval: 6 MONTHS

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedant pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Liva birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other (specify) 9☐Unknown

23d. Date of delivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was casa referred to medical examinar? 1☐Yes 2☒No

28. Placa of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Mannar of Death: 1☒Natural 2☐Accidant 3☐Suicide 4☐Homicida 5☐Panding investigation 6☐Could not ba determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, daath occurred at tha time, data and place, and dua to tha cause(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, dete and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Peter A. Good MD

29c. License number: 21005

29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): PETER A. GOOD MD 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24076

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert E. Vogel

2. Date of Death (Month, Day, Year): July 28, 2001

3. Time of Death: 11:35 A.M.

4a. Facility Name (If not institution, give street and number): 137 Foxwell Bend Road

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-44-8007

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 12, 1945

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 137 Foxwell Bend Road

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: General Electrical

17. Father's Name (First, Middle, Last): Clarence E. Vogel

18. Mother's Name (First, Middle, Maiden Surname): Audrey Brown

19a. Informant's Name/Relationship (Type, Print): Linda L. Vogel Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 137 Foxwell Bend Road, Glen Burnie, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Memorial Park

Date: Jul 31 2001

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: M01220

22. Name and Address of Facility: Singleton Funeral Home, 1 Second Ave Glen Burnie, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Bladder Cancer — 7/99

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy Snow

29c. License number: D24149

29d. Date signed (Month, Day, Year): 7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dorothy Snow, M.D., 10 N. Greene Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: D G Sparks

DHMH 16 Rev 6/95

ORIGINAL

RJD
TERRY VACEK
01-4257-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
TERRY	L.	VACEK	JULY 28, 2001	0111 A.M.

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-82-9992	1☒M 2☐F	40 Yrs.			SEPT. 24, 1960	WV

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CARROLL	MARRIOTTSVILLE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7585 PRINCE ANDREW COURT	21104	U.S.A.

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		CO-OWNER	COLLISION REPAIR

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
MELVIN T. TURNER	BETTY MILLER

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
ROBIN A. VACEK (WIFE)	7585 PRINCE ANDREW COURT, MARRIOTTSVILLE, MD. 21104

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)	LAKE VIEW MEMORIAL PARK	8/1/2001	SYKESVILLE, MARYLAND

21. Signeture of Funeral Service Licensee	22. Neme end Address of Facility
	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFRCT

Due to (or es e consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes an eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of ceuse of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Wes case referred to medicel examiner?	26. Place of Deeth (Check only one)	
1☒Yes 2☐No	Hospitel: 1☐Inpatient 2☒ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) end menner es stated.
2☒ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
Marjorie Bellhorn	O.C.M.E.	JULY 28, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
H. BRYDSON A. KOKOSKA M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signeture
JUL 31 2001	Deputy D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Dorothy	Winand	July 27 2001	11:54 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213 26 6898	1☐M 2☒F	72 Yrs.					June 6, 1929	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Essex	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
320 St. Georges Rd.	21221	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Cafeteria Worker	Balto., Co. Md.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Jones	Marie Brune

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harry E. Winand (Husband)	320 St. Georges Rd. Baltimore, Md. 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Md. Veterans Cemetery	8/2/2001	Garrison Forest, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John W. Burkowske MO1091	Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. third degree heart block	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. endocarditis	2 weeks
	c.	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☒No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rebecca Hill	RES-000	July 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rebecca Hill 600 North Wolfe Street BALTIMORE, MD. 21205

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Hugh	White		July 26 2001	13:04

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
256-54-0172	X 1 M 2 F	64 Yrs.					Dec. 2, 1936	GA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
NJ	Camden	Haddonfield	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
47 Trueman Avenue	08033	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5+	College Professor	Religion / Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clayton White	Marjorie Hines

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann White / Wife	47 Trueman Avenue, Haddonfield NJ 08033

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Bayview Crematory	July 27, 2001	Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert teilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. fungal infection	14 days
Due to (or as a consequenca ot):	Leukemia	12 years
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence ot):		
	c.	
Due to (or es e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Dtd tobacco uss contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24e. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Netural 2 Accident 3 Sulcide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Piece of Injury - At home, term, street, tactory, office building, etc. (Specify)			28t. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Hetty Carraway MD	RES-000	July 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hetty Carraway Johns Hopkins Hospital 600 North Wolfe Street Baltimore Maryland 21287

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signeture
JUL 31 2001	D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANN L. WATTS
2. Date of Death Month/Day/Year: JULY 25 2001
3. Time of Death: 2:30 AM
4a. Facility Name (If not institution, give street and number): Mariner Health of Glen Burnie
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-74-7040
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 101 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 3, 1899
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No X
10e. Street and Number: 2459 Harriet Avenue
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced XX
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No X Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 5
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Leidig
18. Mother's Name (First, Middle, Maiden Surname): Catherine Fink

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary LeCompte (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2459 Harriet Avenue Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial X 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery
Date: 7/27/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Valerie L. Polyniak
22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 East Patapsco Avenue Baltimore, MD. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — 2 years

Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elliott Gorbatym D
29c. License number: D20094
29d. Date Signed (Month, Day, Year): 7/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliott Gorbatym MD 7845 Oakwood Rd, Glen Burnie, md, 21061

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Bernita D Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24081

WISE, CHARLES
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Alton Wise
2. Date of Death: Month July Day 28 Year 2001
3. Time of Death: 9:47 p.m.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-28-1229
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 1, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 402 N. Essex Avenue
10f. Zip Code: 21221
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 1953 1961
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Shipping

17. Father's Name (First, Middle, Last): George Wise
18. Mother's Name (First, Middle, Maiden Surname): Catherine O'Toole

19a. Informant's Name/Relationship (Type, Print): Mary Verlina Wise (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 N. Essex Avenue Essex, Maryland 21221

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gard. Date: 8/2/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Michael C. Jaffe M00938
22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, MD 21221

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIOGENIC SHOCK	3 Days
Due to (or as a consequence of): b.	MYOCARDIAC INFARCTION	1 Week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
INTERSTITIAL LUNG DISEASE
Dyslipidemia
CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: RD 20713
29d. Date signed (Month, Day, Year): July 28, 2001
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Aarohi Ambadekar, M.D. - 9000 Franklin Square Drive, Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Geraldine B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24082

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
James	E.	Wilburn Sr.	JULY	26	2001	15:44 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST AGNES HOSPITAL	BALTIMORE	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-44-8255	1☒M 2☐F	72 Yrs.					March 26 1929	Kentucky

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1927 Casadel Ave.	21230	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Sweeper Operator	Baltimore City Dept. of Public Works

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jess E. Wilburn	Truie M. Moore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Phyllis J. Chalk (Daughter)	4617 Kavon Ave., Baltimore, Md. 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Bayview Crematory	7/31/2001	Baltimore, Md.

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
Paul S. Polyniak	McCully-Polyniak Funeral Home P.A. 237 E. patapsco Ave. Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	1 DAY
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

RENAL FAILURE

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑**Certifying Physicien:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Appea MD	14441	JULY, 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUISA APPEA - DANQUAH, 900 CATON AVE, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME WILBURN, JAMES

15+1

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Whittie

2. Date of Death (Month, Day, Year): July 29, 2001

3. Time of Death: 12:30pm

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-01-3326

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 18, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3408 Roselawn Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Harry Kelly

18. Mother's Name (First, Middle, Maiden Surname): Ethel Loats

19a. Informant's Name/Relationship (Type, Print): James Kelly- Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1543 Kennywick Road Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): New Cathedral Cemetery

Date: 8/2/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain ▶ Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 45min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia stroke

ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edward A Seidel

29c. License number: D38956

29d. Date signed (Month, Day, Year): July 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Seidel, 5601 Loch Raven, Baltimore, Maryland 21239

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: ▶ per D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMND ITM#7 PR. F.H. G797 7-31-01 JAB

Reg. No. 2001 24084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
HYMAN	WEISS	JULY - 29 - 2001	7:47 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LEVINDALE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
139-03-7594	1☐M 2☐F	88 ~~87~~ Yrs.			OCT 1 1912	NJ

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3203 OLD POST DRIVE	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		SALESMAN	S. SCHAPIRO & SONS

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
NATHAN WEISS	CLARA SILVERMAN

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
MRS. HARRIET NUSBAUM/ DAUGHTER	8305 MARCIE DRIVE BALTIMORE, MD. 21208

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	ARLINGTON- CHIZUK AMUNO	7/30/01	BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Robert Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	End stage dementia	7 years
Due to (or as a consequence of): b.	Hypertension	7 years
Sequentiellty list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of): c.	Coronary artery disease	7 years
d.		

Part II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uae contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner steted.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
M Weiss MD	D44817	July 29-2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Subhil Tejani 2434 W Belvedere ave, Baltimore

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signeture
JUL 31 2001	Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Weiss, Hyman
6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Marie Wilkins

2. Date of Death (Month, Day, Year): July 28, 2001

3. Time of Death: 6.30 Am

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 136-20-9967

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/8/1927

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13 Arwell Court

10f. Zip Code: 21236

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frank Piperata

18. Mother's Name (First, Middle, Maiden Surname): Theresa Vaccaro

19a. Informant's Name/Relationship (Type, Print): Richard C. Wilkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Arwell Ct. Perry Hall, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley

Date: 8/1/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John J Offutt Jr

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wilkins Elizabeth

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — 8 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Cancer — Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel Braunstein MD

29c. License number: D0056636

29d. Date signed (Month, Day, Year): July 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Joel Braunstein 9000 Franklin Square Drive Baltimore, MD. 21237

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001

32. Registrar's Signature: Penny P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Laura R. Zekas
CJ
01-4277-003

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24086

UNPENDED 080801:ITEMS#23a,b,27 per ME G798 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey	Year	3. Time of Death
LAURA	R.	ZEKAS	July	28	2001	01:59 P.M.

4a Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of Deeth	4c. County of Death
North Arundel Hospital	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
220-90-4446	1☐ M 2☒ F	31 Yrs.					NOV. 22, 1969	MARYLAND

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐ Yas 2☒ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
464 GLEN MAR ROAD, APT. A2	21061	U.S.A.

11. Marital Stetus	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Giva Year or Dates:	1☐ Yas ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SORTER	U.P.S.

17. Father's Nema (First, Middla, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
MILTON R. LECHOWICZ	GLORIA SIEGERT

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code)
MRS. GLORIA LIBERTY (MOTHER)	572 SHORE ACRES ROAD, ARNOLD, MARYLAND 21012

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other pieca) Date	20c. Location - City or Town, Steta
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HILLCREST MEMORIAL GARDENS 8/2/2001	ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CARDIAC ARRHYTHMIA	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Causa (Diseasa or injury thet initiated avents resulting in deeth) Last	b. MITRAL VALVE PROLAPSE	
	Due to (or as e consequence of):	
	c.	
	Dua to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cauae of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to complation of cause of deeth?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical exeminar?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☑ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner es stated.
2☒ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ J. Pestaner, M.D	O.C.M.E.	July 29, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
JUL 31 2001	▶ Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Isaac R. Alamo
2. Date of Death (Month, Day, Year): July 11, 2001
3. Time of Death: 4:20PM
4a. Facility Name (If not institution, give street and number): 5808 36th Avenue
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 599-40-7242
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 25, 1925
9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5808 36th Avenue
10f. Zip Code: 20782
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: Puerto Rican
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Juilo Alamo
18. Mother's Name (First, Middle, Maiden Surname): Rafaela Rodriguez

19a. Informant's Name/Relationship (Type, Print): Norma M. Alamo- Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8171 Sheffield Court Jessup MD 20794

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Guaynabo Municipal Cem
Date: 7-20-01
20c. Location - City or Town, State: Guaynabo, Puerto Rico

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. END STAGE COLON CANCER

Due to (or as a consequence of):
b. with metastases — 3yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension — 20yr

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibillerturi
Diabetes Mellites,
Perpherel Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Allen Reilly MD
29c. License number: D54749
29d. Date signed (Month, Day, Year): July 12, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4805 Benson Avenue, Baltimore, MD 21227

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24088

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kathryn Margaret Acton
2. Date of Death — Month: July; Day: 16; Year: 2001
3. Time of Death: 8:00PM
4a. Facility Name *(If not institution, give street and number)*: 7113 Langley Court
4b. City, Town, or Location of Death: Hughesville
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-92-2101
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: 5/8/27
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Hughesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7113 Langley Court
10f. Zip Code: 20637
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian
16b. Kind of Business/Industry: St. Ignatius School

17. Father's Name *(First, Middle, Last)*: James Kirkpatrick
18. Mother's Neme *(First, Middle, Maiden Surname)*: Beatrice Edna Leap

19a. Informant's Name/Relationship *(Type, Print)*: John Acton/Son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 7113 Langley Court Hughesville, Md. 20637

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Washington National Cem.
Date: 7/20/01
20c. Location - City or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: George P. Kalas Jr.
22. Neme and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth)
a. Ovarian Cancer

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy tindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan A. Mathur
29c. License number: D28352
29d. Date signed *(Month, Dey, Year)*: July 17, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24089
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
TONY	BIENOSE	AGHOLOR	July 12, 2001	10:14 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-29-7693	1[X] M 2[ ] F	23 Yrs.			Sept. 22, 1977	Nigeria

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince Georges	Beltsville	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4621 Garrett Avenue	20705	Nigeria

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	Student	College

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anthony Ofuzim Agholor	Rose Nkechi Nwoko

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ndidi Agholor (Sister)	4621 Garrett Ave. Beltsville, Md. 20705

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Family Cemetery	07-25-01	Lagos, Nigeria

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wanda C. Bacon CE0361	Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D. C. 20010

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Atrial Flutter	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as e consequence of): Cardiomyopathy	5 years
	b. Due to (or es e consequence of): Muscular Dystrophy	15 years
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel deeth 3[ ] Ectopic pregnancy 4[ ] Pregnant et time of deeth 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of ceuse of deeth?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[ ] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.
2[ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ [signature]	D33463	July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. Reid Thompson, M.D. Johns Hopkins Hospital Baltimore, Md.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

4

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24090

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emily Adetayo

2. Date of Death: Month 07 Day 12 Year 2001

3. Time of Death: 3:34am

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: N/A

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months Days 15

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): 06-27-01

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 16037 Dorset Rd.

10f. Zip Code: 20707

10g. Citizen of What Country? USA

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Eduetion (Specify only highest grade completed): Elementery/Secondery (0-12) N/A; College (1-4or 5+)

16a. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Neme (First, Middle, Last): Michael Adetayo

18. Mother's Neme (First, Middle, Maiden Surname): Kikelomo Obaweya

19a. Informent's Neme/Reletionship (Type, Print): Michael Adetayo/Father

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 16037 Dorset Rd. Laurel, MD 20707

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Riverdale Cremetory

Dete: 7/18/01

20c. Location - City or Town, Stete: Riverdale, MD

21. Signeture of Funerel Service Licensee: K. Wils

22. Neme end Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in deeth)

a. Respiratory Failure

Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

b. Prematurity

Due to (or es e consequence of):

c. Intrauterine growth retardation

Due to (or es a consequence of):

d. Sepsis

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Katherine C. White M.D.

29c. License number: D0028737

29d. Date signed (Month, Day, Year): 07/12/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Katherine C. White, MD 1500 Forest Glen Rd. Silver Spring, MD 20910

State Registrar

31. Dete filed (Month, Dey, Year): JUL 18 2001

32. Registrer's Signeture: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kurt Alfred Alscher
2. Date of Death: Month July Day 14, Year 2001
3. Time of Death: 7:11P M
4a. Facility Name (If not institution, give street and number): 4183 Log Teal Drive
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 578-10-0210
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 27, 1917
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4183 Log Teal Drive
10f. Zip Code: 20603
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1945-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ornamental Iron Worker
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Karl Paul August
18. Mother's Name (First, Middle, Maiden Surname): Bertha Emma Kilian

19a. Informant's Name/Relationship (Type, Print): Jean E. Genua (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6202 Hemlock Way Clinton, Maryland 20735

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland State Veterans Cemetery; Date: July 19, 2001
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Kelli Pate
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
b. CEREBROVASCULAR DISEASE.
Due to (or as a consequence of):
c. CHRONIC PULMONARY DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA
MYELOPROLIFERATIVE DISORDER

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: R.B. Samtani MD
29c. License number: D27744
29d. Date signed (Month, Day, Year): 7/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raj B. Samtani, M.D. 11340 Pembrooke Square #212 Waldorf, Md. 20603

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

ANEMIA
MYELOPROLIFERAT

x

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Christopher Abbott
2. Date of Death: Month July Day 5, Year 2001
3. Time of Death: 11:55 a M
4e. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-56-3918
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-09-43
9. Birthplace (State or Foreign Country): Wash., D. C.

Usual Residence of Decedent

10a. State: Md
10b. County: Prince Georges
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 11104 Teaberry Way Court
10f. Zip Code: 20735
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Courier
16b. Kind of Business/Industry: Delivery Service

17. Father's Name (First, Middle, Last): John Abbott
18. Mother's Name (First, Middle, Maiden Surname): Alva Farmer

19a. Informant's Name/Relationship (Type, Print): Trudie M. Wiggins (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11104 Teaberry Way Court Clinton, Md. 20735

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Northern Virginia Crematory
Date: 07-13-2001
20c. Location - City or Town, State: Arlington, Va.

21. Signature of Funeral Service Licensee: Wanda C. Bacon CCO 361
22. Name and Address of Facility: Bacon Funeral Home, Inc. 3447 14th St., N. W. Washington, D. C. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Immediate Cause (Final diseese or condition resulting in death): a. Congestive Heart Failure — Approximate Interval Between Onset and Death: years

Due to (or as e consequence of): b. Cardiomyopathy — years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Sepsis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D-32332
29d. Date signed (Month, Dey, Year): July 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. K. Gupta, M.D. 9801 Georgia Ave., Suite 220 Silver Spring, Md. 20902

State Registrar

31. Date filed (Month, Day, Yeer): JUL 18 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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5

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Walter B. Alexander	July 11 2001	1:50a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-10-0562	1☒M 2☐F	87 Yrs.			Aug. 15, 1913	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Mt. Airy	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
624 Calliope Way	21771	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manager	C&P Telephone Comp.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Lee Alexander	Minnie Souder

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan A. Strasnick / Daughter	19905 Silver Field Drive, Montgomery Village, Md 20886

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fort Lincoln Cemetery	7/16/2001	Brentwood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line.

		Approximate interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septic Shock	2 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Bilateral Pneumonia	Days-Weeks
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of Oral Squamous cell CA

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as steted.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 26499	July 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ronald E. Miller, MD. #4 Culwell Drive, Mount Airy, Maryland 21771

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM# 23a-line c per phys G/97 073101 ss

Certificate of Death

Reg. No. 2001 24094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT I. ALSTROM

2. Date of Death Month Day Year: June 14 2001

3. Time of Death: 1428 M

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 013-16-7674

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR 25, 1916

9. Birthplace (State or Foreign Country): CT

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: TILGHMAN

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 21737 CAMPER CIRCLE

10f. Zip Code: 21671

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE SALES ENGINEER

16b. Kind of Business/Industry: SMALL ENGINE

17. Father's Name (First, Middle, Last): ALBERT F. ALSTROM

18. Mother's Name (First, Middle, Maiden Surname): MARION THOMAS

19a. Informant's Name/Relationship (Type, Print): DOROTHY J. ALSTROM/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2173 CAMPER CIRCLE TILGHMAN, MD 21671

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): CHESAPEAKE CREMATION CTR

Date: 6-16-01

20c. Location - City or Town, Stete: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ M. [illegible] Newnam III CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN &NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Rt sided CVA involving Parietal

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Occ. P.tal lobe, Basal gangl.a & Cerebellum — 6 days

Due to (or as a consequence of):

c. ~~CAD dell~~ HTN

Due to (or as a consequence of):

d. ~~HTN~~

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnency 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

A valve replacement

Carotid artery disease.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown

24a. Was an autopsy performed? 1 Yes 2 ✓ No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 ✓ No

25. Was case referred to medical examiner? 1 Yes 2 ✓ No

28. Place of Death (Check only one): Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ E. Zabel Nega MD

29c. License number: D46366

29d. Date signed (Month, Day, Year): 06-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELIZABETH NEGA, M.D. 219 S. WASHINGTON ST EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JUN 18 2001

32. Registrar's Signature: ▶ P. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Albert Alstrom

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended Hs 23a-(b), 25; nls, 7/11/01, Allegany Co. per phys

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24095

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Agnes Arnold
2. Date of Death Month 07 Day 09 Year 2001
3. Time of Death: 0335
4a. Facility Name *(If not institution, give street and number)*: Frostburg Village Nursing Home
4b. City, Town, or Location of Death: Frostburg
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 218-16-4037
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October16,1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 366 Sampson Rock Road
10f. Zip Code: 21532
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Clarence Raley
18. Mother's Name *(First, Middle, Maiden Surname)*: Barbara McKenzie

19a. Informant's Name/Relationship *(Type, Print)*: Robin Shaver
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 230 Sampson Rock Road Frostburg,Maryland 21532

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arnold-Layton Cemetery
Date: July12,2001
20c. Location - City or Town, State: Finzel, Maryland

21. Signature of Funeral Service Licensee: John R. Durst
22. Name and Address of Facility: Durst Funeral Home P.A. 57 Frost Avenue Frostburg, maryland 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	sepsis syndrome	02 days
Due to (or as a consequence of): b.	Aspiration of Lung	02 mo.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	cerebral infarction	02 mo
d.		

July 11, 2001

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wonsock Shin MD
29c. License number: D0055325
29d. Date signed *(Month, Day, Year)*: July 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WONSOCK SHIN 48 Town Terrace Suite 204 Frostburg, MD 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 11 2001
32. Registrar's Signature: Regina D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A 1/29/01-Y

per G. Price 7/11/01

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24096

Amend# 29d.Per Phys.PGC 7-16-01 cr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Year	3. Time of Death
Edmund	Beckett	Sr.	July 4, 2001	10:15am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Health Care of Southern Maryland	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
579-30-8492	1[X] M 2[ ] F	73 Yrs.			Sept. 9, 1927	Asbury Park, NJ

Usuel Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Forestville	1[X] Yes 2[ ] No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
8112 Phelps Place	20747	United States

11. Maritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Yeer or Detes:	1[ ] Yes 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		Commercial Driver	Government

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
James Washington Beckett	Marbel Ellis

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Vernetta Beckett / Wife	8112 Phelps Place Forestville, Md. 20747

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1[X] Buriel 2[ ] Cremetion 3[ ] Removel from Stete 4[ ] Donetion 5[ ] Other (Specify)	Washington National	7/9/01	Suitland, Maryland

21. Signeture of Funerel Service Licensee: Ava Mitchell

22. Neme end Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert tailure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Pneumonia

Due to (or es a consequence of):

b. CHF

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest

Due to (or es e consequence of):

c. Infective Endocarditis

Due to (or es e consequence of):

d.

Pert ii. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

ESRD on HD, CAD

Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[X] Probably 4[ ] Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings eveilable prior to completion of ceuse of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Wes cese referred to medicel examiner? 1[ ] Yes 2[X] No

26. Piece of Deeth (Check only one)

Hospitel: 1[ ] Inpetient 2[ ] ER/Outpetient 3[ ] DOA

Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Deeth: 1[X] Neturel 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigetion 6[ ] Could not be determined

28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
	M	1[ ] Yes 2[ ] No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1[X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2[ ] **Medicel Examiner:** On the basis of exemineticn and/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	D53219	~~07 13 2001~~ 7/16/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Zafar A. Ansari, M.D. 7 E Post Office Rd. Waldorf, MD. 20602

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

State Registrar

31. Dete filed (Month, Dey, Year): JUL 16 2001

32. Registrer's Signeture: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Gus Babest
2. Date of Death: Month July Day 12, Year 2001
3. Time of Death: 8:40P.M.

4a. Facility Name (If not institution, give street and number): Woodside Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 221-09-1365
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 7, 1915
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 13608 Old Gunpowder Road
10f. Zip Code: 20707
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Gus J. Babest
18. Mother's Name (First, Middle, Maiden Surname): Pauline Panagaki

19a. Informant's Name/Relationship (Type, Print): Joanna Babest - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13608 Old Gunpowder Rd. Laurel, Maryland 20707

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 7/16/2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 1week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amendhiratta MD
29c. License number: D38262
29d. Date signed (Month, Day, Year): July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR A MENDHIRATTA MD 2401 Research BLVD Suite 340 Rockville MD 20850

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24098

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert Doran Breinin

2. Data of Deeth — Month: July; Dey: 13; Yaar: 2001

3. Time of Death: 11:25 p.m.

4a Feclity Name *(If not institution, giva straat and number)*: Prince George's Hospital Center

4b. City, Town, or Location of Deeth: Cheverly

4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 063-28-3512

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: June 27, 1934

9. Birthplace *(Stata or Foreign Country)*: Pennsylvania

Usuel Residenca of Decedent

10e. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bladensburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4302 54th Place

10f. Zip Code: 20710

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decadent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: Korean War

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Deputy Sheriff

16b. Kind of Business/Industry: Prince George's County

17. Fether's Neme *(First, Middle, Last)*: Leonard Breinin

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Sar Branse

19e. Informent's Name/Relationship *(Type, Print)*: Peggy Breinin - Spouse

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4302 54th Place, Bladensburg, Maryland 20710

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or othar place)*: Metropolitan Crematory

Date: 7/17/2001

20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert T. May

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth) e. SePSis

Due to (or es e consequenca of): b. Endocurditis

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest

Due to (or es e consequence of): c. Mitral valve disease.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: Esophagitis

23b. Did tobecco use contribute to the ceuse of deeth? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings aveileble prior to completion of causa of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Invastigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to tha ceuse(s) end menner stated.

29b. Signeture end title of certifier: M. Surfaraz M.D.

29c. License number: D48042

29d. Date signed *(Month, Dey, Year)*: 7/16/01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 5810 Valerian lane Bethesda Maryland 20852.

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JUL 18 2001

32. Registrer's Signeture: per G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(2)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #'s 10e.19b.& 20c.Per FH PGC 7-25-01 cr **Certificate of Death** Reg. No. 2001 24099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Alberta W. Black	July 18 2001	7:45 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Greater Laurel Hospital	Laurel	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
159-50-9259	1☐M 2☒F	93 Yrs.			Dec 11 1907	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Lanham	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5621 Ellerbie ~~St.~~ Ct.	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George E. Wynne	Cora Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Herbert W. Black - Son	5621 Ellerbie ~~St.~~Ct. Lanham, MD 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Jefferson Mem. Park	July, 21, 2001	Pittsburgh, ~~Pittsburg,~~ PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D24721	July 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Syed Sasiq 14333 Laurel-Bowie Rd. Laurel, MD 20708

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24100

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clarence Booze
2. Date of Death Month: July Day: 17 Year: 2001
3. Time of Death: 7:30AM M
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park, MD
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-12-9381
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-25-1922
9. Birthplace *(State or Foreign Country)*: Quantico, VA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5828 33rd Ave
10f. Zip Code: 20782
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: James Booze
18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Fleet

19a. Informant's Name/Relationship *(Type, Print)*: Lillian Booze
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5828 33rd Ave. Hyattsville, MD 20782

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
Date: July 24, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: K. Wilson
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. STROKE
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Steven Fuller, Ph.D., D.C.
29c. License number: H3607
29d. Date signed *(Month, Day, Year)*: 7-17-01
30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Steven Fuller 7600 Carroll Ave., Takoma Park, MD 20912

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001
32. Registrar's Signature: Deputy G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey Year	3. Time of Death
Carroll E. Brittan, Jr.		July 17, 2001	1:37 a.M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
Southern Maryland Hospital	Clinton	Prince Georges	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-48-9126	X 1 M 2 F	61 Yrs.			Feb. 2, 1940	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince Georges	Ft. Washington	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1306 Old Drummer Boy Lane	20744	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Yeer or Detes:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Wharehouseman	Robinson Term.

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Carroll E. Brittan, Sr.	Vernene Peterson

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Emma Brittan (Wife)	1306 Old Drummer Boy Lane, Ft. Washington, Md. 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
X X Buriel 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify)	Cedar Hill Cemetery	7-20-01	Suitland

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
Phillip Bue	Lewis Funeral Home 311 N. Patrick St., Alex., Va.

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cardiopulmonary failure

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. ruptured gallbladder

Due to (or as a consequence of):

c. sepsis.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal deeth 3 Ectopic pregnency 4 Pregnent et time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 No

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end manner es steted.

2 **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Tong Ma	D55086	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tong Ma, 7501 Surratts Rd. #303, Clinton, Md. 20735

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
JUL 20 2001	D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

(5)

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24102

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ingeborg Banks
2. Date of Death (Month, Day, Year): July 18, 2001
3. Time of Death: 10:12AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: C[inton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 420-33-0645
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 18,1931
9. Birthplace (State or Foreign Country): France

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 11889 Homestead Place
10f. Zip Code: 20601
10g. Citizen of What Country? Perm. Resident U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
18b. Kind of Business/Industry: Shipping

17. Father's Name (First, Middle, Last): Anton Ohmer
18. Mother's Name (First, Middle, Maiden Surname): Anni Schieber

19a. Informant's Name/Relationship (Type, Print): Glenn N. Banks (Husband)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 11889 Homestead Place Waldorf, Maryland 20601

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Lee Crematory
Date: July 21, 2001
20c. Location - City or Town, State: Clinton Maryland

21. Signature of Funeral Service Licensee: Louis L. Grant
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):
b. Ischemic Cardiomyopathy — (2 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary Hypertension
Mitral Regurgitation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2☐Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Varkey Mathew
29c. License number: D45435
29d. Date signed (Month, Day, Year): 7/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Varkey Mathew M.D. 2419 Solomons Island Road Huntingtown, MD 20639

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24103

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jencie M. Braddy

2. Date of Death: Month July Day 17 Year 2001

3. Time of Death: 1510 M

4a. Facility Name (If not institution, give street and number): Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-56-4440

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 23, 1942

9. Birthplace (State or Foreign Country): Wash., DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 6412 Hawthorne St.

10f. Zip Code: 20785

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Federal Worker

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Lawson Lee

18. Mother's Name (First, Middle, Maiden Surname): Viola Booker

19a. Informant's Name/Relationship (Type, Print): Sonja Lee - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6412 Hawthorne St., Landover, MD 20785

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: July 24, 2001

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Breast cancer

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D43662

29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyce PG Hosp 3001 Hospital Drive, Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001

32. Registrar's Signature: G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24104

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Lucille Victoria Brown	July 17, 2001	3:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
230-10-9461	1☐M 2☒F	86 Yrs.			Nov. 6, 1914	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Elkridge	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
452 Deep Run Parkway	22127	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Grocery Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Shackelford	Flossie Myers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charlotte Long - Daughter	452 Deep Run Parkway., Elkridge, MD 22127

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory July 18, 2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dennis Pittman	Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D24997	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Luis A. Casas, M.D. 8317 Cherry Lane. Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vernon Milton Bollinger
2. Date of Death (Month, Day, Year): July 15, 2001
3. Time of Death: 4:59 a.m.
4e. Facility Name (If not institution, give street and number): Gilchrist Center for Hospice Care
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-30-9903
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 25, 1929
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 40 Hanover Road
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-53
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist/Dye Setter
16b. Kind of Business/Industry: Telemecanique Corp.

17. Fether's Neme (First, Middle, Last): James Bollinger
18. Mother's Neme (First, Middle, Maiden Surneme): Nora Berngen

19e. Informent's Neme/Reletionship (Type, Print): Eleanor W. Bollinger - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 40 Hanover Rd. Reisterstown, Md. 21136

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cramatory or other piece): New Cathedral Cem. Date: July 18, 2001
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: Justin R. Dunbar
22. Name end Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failura. List only ona causa on eech line.

		Approximete Intervel Batween Onset and Death
Immediete Causa (Final diseese or condition rasulting in deeth) e.	Lung Cancer	years
	Due to (or es a consequence of):	
Sequentially list conditions, if any, laading to immediate ceusa. Entar Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last b.		
	Due to (or es a consequence of):	
c.		
	Due to (or es a consequence of):	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 1 [ ] Yas 2 [X] No

25. Was cesa rafarred to medicel axaminar? 1 [ ] Yes 2 [X] No

26. Placa of Daath (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be detarmined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29e. Certifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to tha ceuse(s) and mennar as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, daath occurred at tha time, data and place, and dua to tha causa(s) end mannar stated.

29b. Signeture end title of certifier: W. Anthony Riley, MD
29c. License number: D25225
29d. Dete signed (Month, Dey, Year): July 15, 2001

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print): W. A. Riley 6901 N. Charles St. Balto. Md 21204

State Registrar

31. Data filed (Month, Day, Year): JUL 16 2001
32. Registrer's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerei director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Vernon Bollinger July 15, 2001 0459

WJR 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN PAUL BOYTER, SR.

2. Date of Death: Month: July Day: 15 Year: 2001

3. Time of Death: 0700

4a. Facility Name (If not institution, give street and number): 2201 Bear Run Road

4b. City, Town, or Location of Death: Taneytown

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 182-14-1492

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months: Days:

If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): Aug. 31, 1921

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll County

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2201 Bear Run Road

10f. Zip Code: 21787

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): police officer

16b. Kind of Business/Industry: law enforcement

17. Father's Name (First, Middle, Last): John Boyter

18. Mother's Name (First, Middle, Maiden Surname): Flora Molnar

19a. Informant's Name/Relationship (Type, Print): Mary R. Kaufman / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2201 Bear Run Road Taneytown, Maryland 21787

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium

Date: July 20 2001

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Alan C. Lewis M01072

22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hafeez Syed

29c. License number: D25052

29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hafeez Syed, M.D. 20 Crossroads Drive, Suite 102 Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001

32. Registrar's Signature: Geneva B Yoder

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJ 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24107

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Pauline Barnes

2. Date of Death: Month July, Day 16, Year 2001

3. Time of Death: 12:57 pm

4a. Facility Name (If not institution, give street and number): 319 Berrymans Lane

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-01-9792

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 30 1916

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 319 Berrymans Lane

10f. Zip Code: 21136

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John H. Frank

18. Mother's Neme (First, Middle, Maiden Surname): Ida A. Still

19a. Intorment's Neme/Relationship (Type, Print): Douglas Barnes, Sr./husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 319 Berrymans Lane Reisterstown, MD 21136

20a. Method ot Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☒ Other (Specify) Entombment

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Evergreen Memorial Gardens

Date: 7/19/2001

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Pritts Funeral Home and Chapel, 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heert teilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in death)

e. Myocardial Infarction — One hour

Due to (or es e consequenca ot):

b. Congestive Heart Failure — One day

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

Dde to (or as a consequenca ot):

c.

Due to (or as a consequenca ot):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete ot Injury (Month, Dey Year)

28b. Time ot Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture end title ot certifier ▶ MD

29c. License number: D33184

29d. Date signed (Month, Day, Year): July 17, 2001

30. Neme and address of person who completed cause ot deeth (Item 23a) (Type, Print): Jonathan Kushner 114 Business Center Drive Reisterstown, MD 21136

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001

32. Registrer's Signeture ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJR 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Russell C. Bennett

2. Date of Death — Month: July; Day: 14; Year: 2001

3. Time of Death: 2:00 PM

4a. Facility Name *(If not institution, give street and number)*: 2524 Jennings Chapel Road

4b. City, Town, or Location of Death: Woodbine

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-34-7082

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 18 1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Woodbine

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2524 Jennings Chapel Road

10f. Zip Code: 21797

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Own Farm

17. Father's Name *(First, Middle, Last)*: Edward Bennett

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Majors

19a. Informant's Name/Relationship *(Type, Print)*: Linda Halterman daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2524 Jennings Chapel Road Woodbine, MD 21797

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Poplar Springs Cemetery

Date: July 17 2001

20c. Location - City or Town, State: Mt. Airy, Maryland

21. Signature of Funeral Service Licensee: James B Conway

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AORTIC STENOSIS — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David B. Harding MD

29c. License number: D35965

29d. Date signed *(Month, Day, Year)*: JULY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID B. HARDING, M.D. 602 CENTER ST. # 209 MT. AIRY, MD 21771

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH VIRGINIA BURNS

2. Date of Death (Month, Day, Year): JULY 14, 2001

3. Time of Death: 9:45AM

4a. Facility Name (If not Institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-20-2174

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9215 Oak Tree Circle

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Dorsey Granville Cook

18. Mother's Name (First, Middle, Maiden Surname): Carrie Elizabeth Cramer

19a. Interment's Name/Relationship (Type, Print): Melvin Lamarr Cook / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Evergreen Ave. Frederick, MD 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Crematory

Date: 7/15/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Skkot Cody (Licensed Mortician) 44 Tremaine Court; Baltimore, MD 21244

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Glioblastoma Multiforme — 4

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: D0054619

29d. Date signed (Month, Day, Year): 7/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ravi Yalamanchili, M.D. 400 West 7th Street; Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001

32. Registrar's Signature ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Claude W. Bearinger
2. Date of Death: Month July Day 11 Year 2001
3. Time of Death: 6:45 a.m.
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 218-16-2703
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 31, 1924
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No X
10e. Street and Number: 16224 Harwood Drive, SW
10f. Zip Code: 21532
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: X
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dispatcher
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Loring Bearinger
18. Mother's Name (First, Middle, Maiden Surname): Myrtle (Durbin)

19a. Informant's Name/Relationship (Type, Print): Claudia J. Palumbo daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16224 Harwood Drive SW; Frostburg MD 21532

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park
Date: 7/13/2001
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration pneumonia — 2 months
Due to (or as a consequence of):
b. dysphagia — 2 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Cerebrovascular accidents — 3 years
Due to (or as a consequence of):
d. Right internal Carotid stenosis — 3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease, myocardial infarctions, type 2 diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Michael Zang
29c. License number: D0054426
29d. Date signed (Month, Day, Year): July 11 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael Zang 500 Memorial Avenue, Suite 105 Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 12 2001
32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6
MSS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24111

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew Joseph Bennett
2. Data of Death (Month, Day, Year): Jul 16, 2001
3. Time of Death: 10:05am
4a. Facility Name (If not institution, give street and number): 20 Ridgeway Terrace
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 140-28-6657
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Jul 29, 1939
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 20 Ridgeway Terrace
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Lieutenant Commander
16b. Kind of Business/Industry: U.S. Navy

17. Fathar's Nama (First, Middle, Last): unk
18. Mothar's Nama (First, Middle, Maidan Surnama): Eva unk

19a. Informant's Name/Ralationship (Type, Print): Christina Bennett wife
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 20 Ridgeway Terrace;Cumberland, MD21502

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cemetary, cramatory or othar place): Scarpelli Funeral Home
Date: 7/20/
20c. Location - City or Town, Stata: 2001 Cresaptown, MD

21. Signatura of Funaral Service Licensaa: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death):
a. Arteriosclerotic Heart Disease
Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or injury thet initiated events resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.
Post Traumatic Stress Disorder
Chronic Alcoholism

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings availabla prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case rafarred to medical examinar? 1 [X] Yas 2 [ ] No
26. Placa of Daath (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Hama 5 [X] Rasidanca 6 [ ] Othar (Specify)
27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, daath occurred at tha time, data and place, and dua to the cause(s) and mannar as stated. 2 [X] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and due to tha cause(s) and mannar stated.
29b. Signature and title of cartifier: Paul Snow
29c. Licansa number: D09157
29d. Data signed (Month, Day, Year): July 16, 2001
30. Name and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Data filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ronald Wayne Cary	July 14, 2001	5:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2021 Penderbrook Drive	Crownsville	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
230-82-0178	1☒M 2☐F	44 Yrs.			Mar. 8, 1957	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel	Crownsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2021 Penderbrook Drive	21032	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	Engineer	Goddard Space Center

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred B. Cary	Dorothy Napier

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sally B. Cary wife	2021 Penderbrook Drive, Crownsville, Md. 21032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dale Mem. Gardens	07-17-01	Richmond, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert J. Beall	Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Batwean Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. small cell neuro endocrin tumor	12 mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	▶ Kathy Mellmann	D08110	July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
900 Bestgate Rd Annapolis Md 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24113

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Hensley Cox

2. Date of Death Month Day Year: July 17, 2001

3. Time of Death: 2:45AM M

4a. Facility Name *(If not institution, give street and number)*: 11623 North Marlton Avenue

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-05-6937

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth *(Month, Day, Year)*: July 23, 1905

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11623 North Marlton Avenue

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cosmetologist

16b. Kind of Business/Industry: Cosmetology

17. Father's Name *(First, Middle, Last)*: Emory Hensley

18. Mother's Name *(First, Middle, Maiden Surname)*: Litty Anne Bagman

19a. Informant's Name/Relationship *(Type, Print)*: Phyllis Grabowski (Niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11623 North Marlton Ave, Upper Marlboro, MD 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: July 19, 2001

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: M A D Pat

22. Name and Address of Facility: Lee Funeral Home, Inc. 20735 6633 Old Alexandria Ferry Road Clinton, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Colon

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. E methuselasis

Due to (or as a consequence of):

c. gastero enteseinal bleeding

Due to (or as a consequence of):

d. aortic aneurysm

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Taleghani

29c. License number: D10868

29d. Date signed *(Month, Day, Year)*: 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohmmed Taleghani M.D. 4467 Old Branch Avenue Suite 201 Temple Hills, MD 20748

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24114

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris Wilson Carragher
2. Date of Death (Month, Day, Year): July 17, 2001
3. Time of Death: 9:25 am
4a. Facility Name *(If not institution, give street and number)*: 508 Blick Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 251-14-3184
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Yaer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 10, 1922
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 508 Blick Drive
10f. Zip Code: 20904
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Medical Secretary
16b. Kind of Business/Industry: Providence Hospital

17. Father's Neme *(First, Middle, Last)*: Thomas Wilson
18. Mother's Neme *(First, Middle, Maiden Surname)*: Bessie Rolla

19a. Informent's Neme/Reletionship *(Type, Print)*: Beverly A. Carragher - Daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 508 Blick Drive, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: George Washington Cemetery
Dete: 07/20/01
20c. Location - City or Town, Stata: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Edward F. Mayo
22. Name and Address of Feclity: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediata Cause (Finel disease or condition resulting in deeth)
e. Glioblastoma Multiforme — 11 Months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Dua to (or es e consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Temporal Arteritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar statad.
29b. Signature and title of certifier: Richard Schubert
29c. Licanse number: MD11441
29d. Date signed *(Month, Day, Year)*: July 17, 2001
30. Nema and address of person who completed causa of death (Item 23a) (Type, Print): Richard Schubert, M.D., 3301 New Mexico Avenue, NW, #348, Washington, DC

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 18 2001
32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Mildred	Cowgill	July 13, 2001	6:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
187-16-0906	1☐M 2☒F	80 Yrs.					Dec. 20, 1920	Reading, PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15107 Interlachen Drive	20906	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Seemer	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert E. Meck	Gertrude (Bauknecht)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sharon L. DiFonzo-Daughter	13407 Bartlett St., Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bean Crematory, Inc.	July 18, 2001	Sinking Spring, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ellen L. Woodall	Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Advanced Chronic Obstructive Pulmonary Disease	years
Due to (or as a consequence of):	Cigarette Smoking	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Atrial Fibrillation, Hypertension

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Roger F. Leonard	D 28791	July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roger F. Leonard MD 6116 Executive Blvd, Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sylvia Grace Cary

2. Date of Death Month: July Day: 18, Year: 2001

3. Time of Death: 1:20AM

4a. Facility Name (If not institution, give street and number): Doctor's Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 059-18-1524

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 5, 1921

9. Birthplace (State or Foreign Country): Oklahoma

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 10450 Lottsford Road

10f. Zip Code: 20721

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Biologist

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Boyb B. Cary, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margaret McLaughlin

19a. Informant's Name/Relationship (Type, Print): Cheryl A. Alston - Excutor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10301 Democracy Lane Suit 301 Fairfax, Virginia 22030

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 7-24-01

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Dorothy Jean Watts

22. Name and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltmore Avenue Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ileon Obstruction — one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): b. Aspiration Pneumonia — one week

Due to (or as e consequence of): c.

Due to (or es a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular Accident

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 047603

29d. Date signed (Month, Day, Year): 07/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William DeBoyce, MD 4000 Mitchellville Rd B216 Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Otto Carlson
2. Date of Death (Month, Day, Year): July 12 2001
3. Time of Death: 9:45 PM
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 141-09-3229
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 13 1916
9. Birthplace (State or Foreign Country): NJ

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 6509 Shenandoah Drive
10f. Zip Code: 21784
10g. Citizen of Whet Country?: USA

11. Maritat Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): electronics technician
16b. Kind of Business/Industry: Bendix Corp.

17. Father's Name (First, Middle, Last): Andrew Carlson
18. Mother's Name (First, Middle, Maiden Surname): Marie Beck

19a. Informant's Name/Relationship (Type, Print): Cheryl Benitez (daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6509 Shenandoah Dr., Sykesville, Md 21784

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 X Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Hebron Cemetery
Dete: 7-18-01
20c. Location - City or Town, Stete: Upper Montclair, NJ

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Stroke — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnant et time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Sepsis

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were eutopsy findings evailable prior to completion of cause of deeth? 1 ☐ Yes 2 X No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medicat examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: 40525
29d. Date signed (Month, Day, Year): July 12, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rudolf Titanji, M.D. Carroll County General Hospital 200 Memorial Ave. Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: ▶ Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

WJL 12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.: 2001 24118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph William Cook

2. Date of Death: Month July, Day 8, Year 2001

3. Time of Death: 5:45p.m.

4a. Facility Name (If not institution, give street and number): Homewood at Crumland Farms

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 120-28-9533

6. Sex: [X] 1 M 2 F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec 28 1925

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: [X] 1 Yes 2 No

10e. Street and Number: 8 Ninth Avenue

10f. Zip Code: 21716

10g. Citizen of What Country: USA

11. Marital Status: 1 Never Married 2 Married [X] 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: PEPCO Dickerson, MD

17. Father's Name (First, Middle, Last): Theodore William Cook

18. Mother's Name (First, Middle, Maiden Surname): Beatrice Santacruce

19a. Informant's Name/Relationship (Type, Print): Joan Marie Hale, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2485 West Tom Watson Drive, Tucson, AZ 85742-8531

20a. Method of Disposition: [X] 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Date: 7/12/01

20c. Location - City or Town, State: Petersville, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams

Barbara A. Williams, Owner

22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Road Brunswick MD 21716

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic Heart Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes [X] 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: [X] 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: [X] 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Casper E. Cline MD

29c. License number: D16428

29d. Date signed (Month, Day, Year): 7/11/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline,M.D 300 West 9th Street Frederick,MD 21701

State Registrar

31. Date filed (Month, Day, Year): JUL 11 2001

32. Registrar's Signeture: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM# 23a-lineb per phys G797 073101 SS

Certificate of Death

Reg. No. 2001 24119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Charles	K.	Cornish	June 28 2001	1020

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Hospital	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-07-2496	1☑M 2☐F	94 Yrs.			July 1, 1906	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	North East	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
105 Erie Court	21901	U.S.A.

11. Mental Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Rece - Americen Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☐Yes 2☑No If Yas, Giva Yeer or Detes:	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Educetion (Specify only highest grade completad)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
10		Longshoreman	ILA Local 1694

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumame)
Sylvester Cornish	Lena Owens

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
George D. Norwood, Sr., Nephew	28 Mahogany Drive, North East, Maryland 21901

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Locetion - City or Town, State
1☑Buriel 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)	Cathedral Cemetery	July 2, 2001	Wilmington, Delaware

21. Signature of Funeral Service Licensee	22. Nama and Addrass of Facility
▶ [signature]	Gee Funeral Home 259 E. Main Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications thet ceused the death. Do not antar tha moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediata Cause (Final diseese or condition resulting in deeth)

a. Cardiac arrest

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated evants resulting in deeth) Last

b. Pneumonia / ~~Acute Respiratory Failure~~

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yas 2☑No	1☐Yas 2☐No

25. Wes cese referred to medicel examiner?	26. Piece of Death (Check only one)	
1☐Yes 2☑No	Hospitel: 1☑Inpatient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et tha time, date end piece, and dua to the cause(s) end menner es stated.

2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier	29c. Licensa number	29d. Date signed (Month, Dey, Year)
▶ [signature]	MD0056426	6/28/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL M. KATZ DO 251 S Bohemia Ave, Leceiton, MD 21913

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
JUL 02 2001	▶ [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Amended #5 20b, Part II; nlo, 7/11/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24120

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sandra Cook
2. Date of Death: Month July Day 9 Year 2001
3. Time of Death: 4:48 AM
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 219-46-2031
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 9, 1945
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11220 Old Mount Pleasant Road
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Nama (First, Middle, Last): Roland Cook
18. Mother's Name (First, Middle, Maiden Surname): Helen (Robinette)

19a. Informant's Name/Relationship (Type, Print): Dewey Cook
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 11220 Old Mt Pleasant ;Cumberland MD 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Scarpelli Funeral Home
Date: 7/6/2001
20c. Location - City or Town, Stete: Cresaptown, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name end Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad thedaath. Do not entar tha mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death): e. Coronary artery heart disease — yrs
Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Dua to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, COPD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yas 2☐ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☒ Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stated.
29b. Signeture and title of certifier: Dpty Med Ex
29c. License number: D 09157
29d. Date signed (Month, Day, Year): July 9 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow, M.D. 124 w 3rd st cumberland Md 21502

State Registrar

31. Dete filed (Month, Day, Year): JUL 11 2001
32. Registrar's Signature: Regina G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3 MLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecil C. Cox
2. Date of Death Month Day Year: JULY 16, 2001
3. Time of Death: 4:50 A.M.
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 234-38-8158
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 10, 1926
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Wiley Ford
10d. Inside City Limits: 1☐ Yes 2☒ No — X
10e. Street and Number: Route 1 Box 65
10f. Zip Code: 26767
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced — X
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — X
If Yes, Give Yeer or Dete: WW II
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No — X Specify:
14. Rece - American Indien, Bleck, White, etc.
Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): 12
College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Delivery Person
16b. Kind of Business/Industry: Potato Chips Co

17. Fether's Neme (First, Middle, Last): James R. Cox
18. Mother's Neme (First, Middle, Maiden Sumeme): Susie L (Baldwin)

19e. Informent's Neme/Reletionship (Type, Print): Joseph R. Cox Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 513 East Oldtown Road;Cumberland MD 21502

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify) — X
20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Scarpelli Funeral Home
Dete: 7/16/2001
20c. Location - City or Town, State: Cresaptown, MD

21. Signature of Funerel Service Licensee: ▶ Nicholas J. Scarpelli
22. Neme and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth)
e. METASTATIC CARCINOMA — 1 month

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last
b. PROBABLE CANCER OF COLON — 2 months

Due to (or es a consequence of):
c.

Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

STATUS POST EXPLORATORY LAPAROTOMY, HISTORY OF AORTIC VALVE PROSTHESIS, HISTORY OF BACTERIAL ENDOCARDITIS, HISTORY OF RENAL CELL CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown — X

24a. Wes an autopsy performed? 1☐ Yes 2☒ No — X
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No — X

26. Plece of Deeth (Check only one)
Hospitel: 1☒ Inpetient — X 2☐ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel — X 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. — X
2☐ Medicel Examiner: On the basis of exemineticn and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: ▶ N.A. Ranjithan
29c. License number: D19318
29d. Date signed (Month, Day, Year): July 16th 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. N. A. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502

State Registrar

31. Dete filed (Month, Dey, Yeer): JUL 16 2001
32. Registrer's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5
2nd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24122

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month Day Year	3. Time of Death
Marjorie	Holton	D'Angelo	July 16, 2001	5:40P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
259-28-8910	1☐ M 2☒ F	78 Yrs.			Sept. 30, 1922	Georgia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Upper Marlboro	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12118 Northwood Drive	20772	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	N/A	Secretary	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rufus Holton	Mary Brinson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dr, John P. D'Angelo (Husband)	12118 Northwood Drive Upper Marlboro, MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cremetory or other place)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resurrection Cemetery	July 20, 2001	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. acute myelocytic leukemia	5 mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): myelodysplastic syndrome	1 year
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D21531	July 16, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G. Peter Pushkas M.D. 11510 Old Georgetown Road Rockville, Maryland 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24123

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hattie Singleton Druitt
2. Date of Death Month / Dey / Year: July 9,2001
3. Time of Death: 9:20am
4a Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home
4b. City, Town, or Location of Death: Largo
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-28-1474
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 84 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-9-1917
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 111 Essenton Drive
10f. Zip Code: 20774
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedant's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Analyst
16b. Kind of Business/Industry: D.C. Govt

17. Father's Name *(First, Middle, Last)*: Isaac Singleton
18. Mother's Name *(First, Middle, Maiden Surneme)*: Minnie Singleton

19a. Interment's Neme/Reletionship *(Type, Print)*: Mr. Bashir Ahmad / Son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 111 Essenton Drive, Upper Marlboro,MD 20774

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other pleca)*: Fort Lincoln Cemetery
Dete: 7-12-01
20c. Location - City or Town, State: Brentwood,MD

21. Signeture of Funeral Service Licensee: [signature] M01285
22. Neme and Address of Facility: Alexander S. Pope Funeral Home, 5538 Marlboro Pike,Forestville,MD 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one ceuse on aach line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)
a. Stroke — Weeks

Due to (or es a consequenca of):
b.

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Dua to (or as a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, tarm, street, tectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, date end pleca, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29b. Signeture and title of certilier: [signature]
29c. License number: D32261
29d. Dete signed *(Month, Day, Year)*: July 11.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Feldman M.D. 9500 Annapolis Rd. Suite A-4

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24124

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty May Depro

2. Date of Death (Month, Day, Year): July 15 2001

3. Time of Death: 10:55A

4a. Facility Name *(If not institution, give street and number)*: 5720 29th Avenue

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-26-1410

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 21, 1922

9. Birthplace *(State or Foreign Country)*: Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5720 29th Avenue

10f. Zip Code: 20782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Department Manager

16b. Kind of Business/Industry: Woodward & Lothrop Store

17. Father's Name *(First, Middle, Last)*: Guy Thompson

18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Irene Yates

19a. Informant's Name/Relationship *(Type, Print)*: Guy J. Stephens - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9238 Rockefeller Lane, Springfield, VA 22153

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park

Date: 07/19/01

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Robert T. May

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester, DO

29c. License number: H00055927

29d. Date signed *(Month, Day, Year)*: July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 3001 Hospital Drive, Cheverly Maryland 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24125

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOYCE MARIE DORN
2. Date of Death: Month JULY Day 16, Year 2001
3. Time of Death: 7:17 AM

4a. Facility Name (If not institution, give street and number): 1916 Barlowe Place
4b. City, Town, or Location of Death: Palmer Park
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 267-58-3480
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1940
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Palmer Park
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1916 Barlowe Place
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): George Harrison
18. Mother's Name (First, Middle, Maiden Surname): Mary Johnson

19a. Informant's Name/Relationship (Type, Print): Julius Dorn Jr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1916 Barlowe Place, Palmer Park, Md. 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Pk | Date: 7/20/01
20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: Belva J Jenkins
22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Road, Landover, Md. 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial infarction caused by
Due to (or as a consequence of): b. Coronary Artery Disease 8 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. Hypertension 23 yrs
Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus type 2, Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Melvin Gerald MD
29c. License number: D07119 MD
29d. Date signed (Month, Day, Year): 7/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Melvin Gerald 2139 Georgia Ave, N.W. Wadh 20001

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature: D. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5 PER FH G808 6/10/02 JH

Certificate of Death

Reg. No. 2001 24126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth M. Dayhoff

2. Date of Death: Month July, Day 17, Year 2001

3. Time of Death: 4:55 AM

4a. Facility Name (If not institution, give street and number): Lorien Nursing Home

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-30-0688 ~~218-14-9936~~

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 26 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Lisbon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16008 Frederick Road

10f. Zip Code: 21765

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward Schellar

18. Mother's Name (First, Middle, Maiden Surname): Annie Barth

19a. Informant's Name/Relationship (Type, Print): Paul Dayhoff, Jr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15919 Frederick Road Lisbon, MD 21765

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Taylorsville Cemetery

Date: July 20 2001

20c. Location - City or Town, State: Taylorsville, MD

21. Signature of Funeral Service Licensee: James B Corum

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CORONARY ARTERY DISEASE — MONTHS

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. URINARY TRACT INFECTION — WEEKS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Spoore M.D.

29c. License number: D0053150

29d. Date signed (Month, Day, Year): JULY 18th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNMALA GUPTA 201-109 BACK RIVER NECK ROAD BALTIMORE MD21221

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 12

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN ELLIOTT DAVIDSON
2. Date of Death: Month July, Day 16, Year 2001
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): 4700 South Chelsea Lane
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-05-5353
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 101 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 25, 1899
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4700 South Chelsea Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Albert Elliott
18. Mother's Name (First, Middle, Maiden Surname): Annie Rebecca Nichols

19a. Informent's Name/Retelionship (Type, Print): R. Miles White II (Great Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 North Bentz Street, Frederick, MD 21701

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Smithsburg Crematory
Date: 7/18/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Ruth E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Arteriosclerotic Heart disease — immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D0001948
29d. Date signed (Month, Day, Year): July 17, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 8218 Wisconsin Ave. Bethesda Maryland 20814.

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EILEEN DICKER	JUNE 22, 2001	1AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HEBREW HOME OF GREATER WASHINGTON	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
081-24-3729	1☐M 2☒F	75 Yrs.			MAY 12, 1926	UNITED KINGDOM

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	ROCKVILLE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6121 MONTROSE ROAD	20852	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes ☒☐No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MAURICE JACOB LAST	SARA STIEBER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ELI DICKER/SON	9722 GLYNSHIRE WAY, POTOMAC, MARYLAND 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	BETH MOSES CEMETERY	JUNE 24, 2001	PINELAWN, NEW YORK

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶ [signature] CAROLINE HEATHER ROSMAN	MO1255	EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gregory A Compton MD	D24942	JULY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GREGORY A. COMPTON, MD 6121 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 31 2001	▶ Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24129

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
JOSEPHINE V. DAWSON	July	6	2001	11:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital-Hospice Unit	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-30-2072	1☐M 2☒F	79 Yrs.			Feb. 19, 1922	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Keyser	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Rt. 6 Knobley Road	26726	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Floral Designer	Flower Shop

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Forest Harvey	Dessie M. Wilson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Diann Evans/Daughter	40 Chickadee Street Keyser, WV 26726

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Potomac Memorial Gardens	July 10 2001	Keyser, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian L. Smith	Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory arrest	One day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Lung Mass & Brain Mets	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Steven Johnson Syndrom, Metastatic Breast CA, COPD, DM AFib, Anemia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☑Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Shiv Khanna	D54004	July 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shiv Khanna M.D. 625 Kent Ave. Cumberland MD 21502.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 12 2001	per B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24130

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Kenneth Donaldson
2. Dete of Deeth: Month July Day 12, 2001 Yeer
3. Time of Deeth: 4:00 P.M.
4e Facility Neme *(If not institution, give street end number)*: 37 Charlestown Street
4b. City, Town, or Location of Deeth: Lonaconing
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-36-7153
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: February 09, 1938
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 37 Charlestown Street
10f. Zip Code: 21539
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Labor
16b. Kind of Business/Industry: Maintenance

17. Father's Name *(First, Middle, Last)*: Billy Donaldson
18. Mother's Name *(First, Middle, Maiden Surneme)*: Marie Nicol

19e. Informent's Neme/Reletionship *(Type, Print)*: Linda Sue Donaldson-Daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7 Turner St.,Cumberland,Md. 21502

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Restlawn Memorial Gardens
Date: July 16, 2001
20c. Location - City or Town, Stete: LaVale,Maryland

21. Signature of Funeral Service Licensee: ▶ Jas E. McKenzie
22. Neme end Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth):
e. Severe Myelofibrosis — 3 years

Due to (or es a consequence of):
b. Severe Pancytopenia

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest

Due to (or es a consequence of):
c.

Due to (or es a consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐Yes 2☐No

25. Wes case referred to medicel examiner? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner as stated. 2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ John Mchannn M.D.
29c. License number: D-17526
29d. Date signed *(Month, Dey, Year)*: July 13, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): John Mchannn MD 902 Seton Drive, Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Dey, Year)*: JUL 17 2001
32. Registrer's Signeture: ▶ Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

NLS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Earl Edwards, Sr.

2. Date of Death: Month July Day 14, Year 2001

3. Time of Death: 7:25P M

4a. Facility Name (If not institution, give street and number): 10804 Knoll Court

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-24-8358

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-20-1926

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10804 Knoll Court

10f. Zip Code: 20772

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Manager

16b. Kind of Business/Industry: Naval Lodge # 4

17. Father's Name (First, Middle, Last): Thomas Earl Edwards

18. Mother's Name (First, Middle, Maiden Surname): Mabel E. Havenner

19a. Informant's Name/Relationship (Type, Print): Steven T. Edwards (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1011-F Airy Hill Court Crofton, MD 21114

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland State Veterans Cemetery

Date: July 18, 2001

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Louis L. Lee

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in deeth)

a. Metastatic Cancer in Liver

Sequentially fist conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the ceuse of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the lime, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Martin O. Weltz

29c. License number: D23743

29d. Date signed (Month, Day, Year): July 17, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Martin Weltz, M.D. 7525 Greenway Center Drive#205 Greenbelt, Md. 20770

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signature: B. Lewis

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification:

01-3930-021
crn
David Robert Egbert

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Robert Egbert

2. Date of Death — Month: July; Day: 15; Year: 2001

3. Time of Death: 12:59 A.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 063-64-4863

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 23 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 20, 1978

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 618 Biggs Avenue

10f. Zip Code: 21702

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): glazer

16b. Kind of Business/Industry: Service Glass

17. Father's Name (First, Middle, Last): Robert A. Egbert

18. Mother's Name (First, Middle, Maiden Surname): Patricia Cunningham

19a. Informant's Name/Relationship (Type, Print): Patricia C. Egbert/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 618 Biggs Avenue Frederick, MD 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: July 19, 2001

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Drowning

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 7-14-2001

28b. Time of Injury: unknown PM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject was driver of car which left roadway into a pond

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Pond

28f. Location (Street and Number or Rural Route Number, City or Town, State): Route 15 Frederick County, Maryland

29a. Certifier (Check only one) 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart Hackly, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ARMAN PIROOZ FAZLI	JULY 14 2001	4:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
National Institutes of Health	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Unknown	1☒ M 2☐ F	25 Yrs.			Nov. 16, 1975	Pune, India

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Montgomery	Germantown	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11314 Brook Run Drive	20876	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4+	Software Professional	MVP Systems, India

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Pirooz Fazli	Monira Yaganegi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pirooz Fazli/Father	11314 Brook Run Drive Germantown, Md. 20876

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donation 5☐ Other (Specify)	Glenwood Cemetery	7-18-2001	Washington, D.C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jr. P. Marshall	Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Overwhelming sepsis	7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Failed engraftment of Bone Marrow transplant	23 days
	c. Due to (or as a consequence of): Acute Lymphocytic leukemia	1 year
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnent in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	
24e. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No	26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	
1☒	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.
2☐	**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	D0057205	7/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DENISE A. GONZALES 10 CENTER DRIVE, BETHESDA, MARYLAND 20892

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
JUL 18 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24134

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clarence Fouch, Jr.

2. Date of Death: Month 07 Day 12 Year 2001

3. Time of Death: 10:00am

4a. Facility Name *(If not institution, give street and number)*: 2244 Alice Ave. #104

4b. City, Town, or Location of Death: Oxon Hill

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 153-28-4723

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 01-31-1938

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2244 Alice Ave. Apt#104

10f. Zip Code: 20745

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Bio Lab Technician

16b. Kind of Business/Industry: Government

17. Fathar's Nama *(First, Middle, Last)*: Clarence Fouch , Sr.

18. Mother's Name *(First, Middle, Maiden Sumame)*: Annie Jones

19a. Informant's Name/Relationship *(Type, Print)*: Lucille Fouch/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2244 Alice Ave. #104 Oxon Hill, MD 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Maryland Veterans Cem.

Date: 7/20/01

20c. Location - City or Town, Stata: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ K. Wils

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — 1 yr.

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were sutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen Staal

29c. License number: P18219

29d. Data signed *(Month, Day, Year)*: 7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Staal, MD 1221 Mercantile Lane, Largo, MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001

32. Registrar's Signatura: ▶ G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ETHEL O FREEMAN
2. Date of Death (Month, Day, Year): July 15, 2001
3. Time of Death: 1:30pm
4a. Facility Name (If not institution, give street and number): Prince Georges Community Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 161-20-8052
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 19, 1919
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4003 Kingsfair Court
10f. Zip Code: 20721
10g. Citizen of Whet Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary
16b. Kind of Busnass/Industry: DC Government

17. Father's Neme (First, Middle, Last): Alexander Owens
18. Mother's Name (First, Middle, Maidan Surname): Hattie Wilson

19e. Informent's Neme/Reletionship (Type, Print): Alexis O. Taylor / Niece
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code): 4003 Kingsfair Court Mitchellville, MD 20721

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Rock Creek Cemetery
Date: 7/20/01
20c. Location - City or Town, Stete: Washington DC

21. Signature of Funeral Service Licensee: ▶ Paulette Henson
22. Name and Address of Facility: Johnson & Jenkins Funeral Home 716 Kennedy ST NW WDC 20011

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in deeth): e. Sepsis — weeks

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebral Infarction Encephalopathy; Respiratory Failure Ventilation Dependent

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Wara eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: ▶ Paul A DeVore MD
29c. License number: D01852
29d. Data signed (Month, Dey, Year): JULY 16 2001

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): PAUL A DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: ▶ P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Francis A. Federici	07 / 18 / 01	8:00P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-32-4958	1☑M 2☐F	74 Yrs.			May 10, 1927	Wash.D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel	Annapolis	☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
312 Broad Creek Dr.	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Photographer	Photography

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anthony Francis Federici	Grace Fabrizio

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mike Federici - Son	312 Broad Creek Dr.,Annapolis, Md.21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ft.Lincoln Cem.	July 21,01	Brentwood,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Beall Funeral Home- 6512 N.W.CrainHwy. Bowie, Md.20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. SEPSIS	2 DAYS
Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnant et lime of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC RECTAL CANCER

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No N/A

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D39037	7-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DS MITCHELL MD AAMC ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24137

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAMELA SHEILA FORD

2. Date of Death Month / Day / Year: July 9, 2001

3. Time of Death: 6:45AM

4a. Facility Name *(If not institution, give street and number)*: 5411 Winston Street

4b. City, Town, or Location of Death: Temple Hills

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-88-2219

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-02-58

9. Birthplace *(State or Foreign Country)*: Wash. D.C.

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2651 Douglas Street, NE

10f. Zip Code: 20018

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disabled

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Lorraine L. Ford

19a. Informant's Name/Relationship *(Type, Print)*: Robyn M. Simms / Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5411 Winston Street, Temple Hills, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Memorial Cemetery

Date: 7-14-01

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: Eric D. Strickland

22. Name and Address of Facility: Strickland Funeral Services, PA, 6500 Allentown Rd., Camp Springs, MD 20748

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Terminal Brain Cancer — 2 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)*: Sister's House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 12382

29d. Date signed *(Month, Day, Year)*: 7-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Kwon, M.D. 2041 Martin Luther King Ave. S.E. Wash. D.C. 20032

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended item#26per MD FCHD,KS 7/19/01

Reg. No. 2001 24138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Isidro O. Flores	July 14 2001	9:43 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
505-32-1254	1☒M 2☐F	76 Yrs.			Feb. 16, 1925	Nebraska

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Thurmont	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7 Vista Court	21788	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yas, Giva Year or Dates:	1☒Yes 2☐No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Foreman	County Road Dept.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francisco Flores	Cruz De La Torre

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sharon K. Ochoa / Daughter	7 Vista Court Thurmont, Maryland 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)	Bayard Cemetery	July 20 2001	Bayard, Nebraska

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Stauffer Funeral Homes, P.A. 104 E. Main Street Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrast, shock, or haart teilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disease or condition resulting in death)	a. Ventricul Fibrillation	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CORONARY DISEASE	24yrs
	Due to (or as a consequence of):	
	c. CARDIOMYOPATHY	20yrs
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D36649	7/16/01

30. Name and address of parson who completed cause of death (Item 23e) (Typa, Print)

Edward P. Riuli, M.D. 180 Thomas Johnson Drive Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signatura
JUL 19 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vivian M. Flores
2. Date of Death (Month, Day, Year): July 15, 2001
3. Time of Death: 0736 am

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 508- 16-5783
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 20, 1923
9. Birthplace (State or Foreign Country): Nebraska

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7 Vista Court
10f. Zip Code: 21788
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary
16b. Kind of Business/Industry: Legal

17. Father's Name (First, Middle, Last): Benjamin McMaster
18. Mother's Name (First, Middle, Maiden Surname): Augusta W. Koester

19a. Informant's Name/Relationship (Type, Print): Sharon K. Ochoa / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Vista Court Thurmont, Maryland 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayard Cemetery
Date: July 20 2001
20c. Location - City or Town, State: Bayard, Nebraska

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 104 E. Main Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Arteriosclerotic Cardiovascular Disease — Years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Prolapsed Valve; Gastric Cancer

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D35164
29d. Date signed (Month, Day, Year): July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr., M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24140

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Lee Glenn Jr.
2. Date of Death (Month, Day, Year): July 16, 2001
3. Time of Death: 11:55 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 224769677
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 26, 1951
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street and Number: 4425 Rena Road
10f. Zip Code: 20746
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: Public School

17. Father's Name (First, Middle, Last): Robert Lee Glenn Sr
18. Mother's Name (First, Middle, Maiden Surname): Sarah Hicks

19a. Informant's Name/Relationship (Type, Print): Robert L Glenn Sr
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2008 Trafalgar Dr. Ft. Washington MD 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Hill
Date: 7/21/2001
20c. Location - City or Town, State: Suitland, MD.

21. Signature of Funeral Service Licensee: Kenneth J. Robinson
22. Name and Address of Facility: Peyton Funeral Home 2205 S. Shirlington Rd, Arl, VA 22206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Bilateral Pneumonia — Approximate Interval Between Onset and Death: unknown

Due to (or as e consequence of):
b. Human Immune Deficiency Syndrome — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):
c. — unknown

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Wes decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Dey / Year

Part II. **Other significant conditions** contnibuting to death but not resulting in the underlying cause given in Part I.: Renal Failure

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. Licanse number: 50454
29d. Date signed (Month, Dey, Yeer): July 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9801 Georgia Avenue Suite 3-35 Silverspring MD 20902

State Registrar

31. Date filed (Month, Dey, Year): JUL 20 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Goodwyn

2. Date of Death Month 07 Day 12 Yaer 01

3. Time of Death 6:00 AM

4e. Facility Name (If not institution, give street and number): Manor Care Nursing Home

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 227-44-4661

6. Sex: [X] M 2 [ ] F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): July 12,1909

9. Birthplace (Stete or Foreign Country): McKenney,Va

Usuel Residence of Decedent

10a. Stete: Md

10b. County: Prince George

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10e. Street end Number: 10410 Tulsa Drive

10f. Zip Code: 20783

10g. Citizan of What Country?: United States

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - Amarican Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | Collage (1-4or 5+):

16e. Dacedant's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Road Worker

18b. Kind of Business/Industry: Virginia State Govt

17. Fathar's Neme (First, Middle, Last): John Belfield Goodwyn

18. Mother's Neme (First, Middle, Maiden Surneme): Hattie Pegram

19a. Informent's Name/Ralationship (Type, Print): George Walter Goodwyn/Son

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 1565 Ritchie Lane,Annapolis,MD 21401

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Othar (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Big Bethel Burial Park | Date: 7-19-01

20c. Location - City or Town, Stete: McKenney,VA

21. Signature of Funeral Service Licensee: Alex S Pope Jr.

22. Name and Address of Facility: Alexander S. Pope Funeral Home, 11315 Lockwood Drive,Silver Spring,MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one causa on eech line.

Approximete Intarval Batween Onset and Daath

Immediate Ceuse (Finel disease or condition resulting in daath) e. Prostate Cancer — 6 years

Due to (or es e consaquenca of):

Sequentially list conditions, if eny, leading to immediate causa. Enter Undarlying Ceuse (Disease or injury thet initieted events resulting in daeth) Last

b. Dua to (or es a consequance of):

c. Dua to (or as a consequanca of):

d.

Part II. Other significant conditions contributing to death but not rasulting in tha underlying cause given in Part I.: Coronary artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings evellable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Placa of Deeth (Check only ona) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residance 6 [ ] Othar (Specify)

27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To tha best of my knowladga, daath occurrad at tha time, date end pleca, and dua to the ceuse(s) end menner es stated. 2 [ ] Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: John Margolis MD

29c. Licansa number: D25430

29d. Dete signed (Month, Dey, Year): 7/12/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): JOHN MARGOLIS, MD 13952 Baltimore Ave. Laurel, MD 20707

State Registrar

31. Dete filed (Month, Dey, Year): JUL 16 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 1/3

CR

(4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23e per PHYG798 8/6/01 EW

Certificate of Death

2001 24142
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Walden Lee Gilkerson	July 13, 2001	2:15p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Pr.Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
223-36-5140	1 M 2 F	70 Yrs.			April 19, 1931	W.Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Calvert	Prince Frederick	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1530 OLd Adelina Road	20678	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates: Army	1 Yes 2 No Specify:	Specify White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Steamfitter-Welder	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leon Gilkerson	Della Eplin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia L.Gilkerson-Wife	1530 Old Adelina Rd.PR.Fredrick 20678

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Cheltenham Vetrans	7-18-2001	Cheltham,Md.

21. Signature of Funeral Service Licensee: Jeff C. Anderson

22. Name and Address of Facility: Dunn & Sons Funeral Service 5635 Eads St,N.E.

Physician /Medical Examiner

CR

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. gastric cancer	5 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No	28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 0056024	July 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth L. Abbott 110 Hospital Road Suite 110 Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(11)

01-3843-033
CHARLOTTE L. GUNN
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24143

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte L. Gunn
2. Date of Death Month / Day / Year: JULY 11 2001
3. Time of Death: 0455
4a. Facility Name *(If not institution, give street and number)*: 4709 MARGIE COURT
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 185-84-5740
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09/09/1944
9. Birthplace *(State or Foreign Country)*: Pittsburg, Pa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4709 Margie Court
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Health

17. Father's Name *(First, Middle, Last)*: Gaylord Leonard
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Farrish

19a. Informant's Name/Relationship *(Type, Print)*: Tama Gunn Hicks/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10135 Prince Place #404 Uppermarlboro Md 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Homewood Cemetery
Date: 7/19/2001
20c. Location - City or Town, State: Pittsburg, Pa

21. Signature of Funeral Service Licensee: Thomas E Willis
22. Name and Address of Facility: Fort Lincoln Funeral Home, 3401 Bladensburg Road Brentwood Md 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stab and Cutting Wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☒ Other *(Specify)* SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicida 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: 7/11/01
28b. Time of Injury: 0447 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject stabbed & cut
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4709 Margie Court Lanham Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JULY 11,2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M King, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24144

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas A. Gantt

2. Date of Death — Month: July; Day: 9; Year: 2001

3. Time of Death: 1758

4a. Facility Name *(If not institution, give street and number)*: 12225 Van Brady Road

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-36-4705

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-07-1939

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12225 Van Brady Rd.

10f. Zip Code: 20774

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Auto Mechanic

16b. Kind of Business/Industry: Private

17. Father's Neme *(First, Middle, Last)*: Louis Edward Gantt

18. Mother's Name *(First, Middle, Maiden Surname)*: Louise Wiseman

19a. Informent's Neme/Reletionship *(Type, Print)*: Georgia Dickerson / Sister

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10810 Westwood Dr., Cheltenhem, MD 20774

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Washington National Cem. — Date: 7/17/01

20c. Location - City or Town, State: Suitland, Maryland

21. Signeture of Funeral Service Licensee: K. Wil

22. Name end Address of Fecility: J.B. Jenkins Funeral Home, 7474 Landover Rd., Landover, Md 20785

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. — Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. Cancer of the Throat

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to Immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2☑ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Salvador Sylvester, DO

29c. License number: H005927

29d. Date signed *(Month, Day, Year)*: July 11, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Salvador Sylvester, 2001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 13 2001

32. Registrer's Signeture: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Agnes Gandy
2. Date of Death (Month, Day, Year): July 14, 2001
3. Time of Death: 10:34 PM

4a. Facility Name (If not institution, give street and number): Bradford Oaks Nursing & Rehab Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 173-18-8114
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/06/1921
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7504 Livingston Road
10f. Zip Code: 20745
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In Home

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Barbra Baron

19a. Informant's Name/Reletionship (Type, Print): Thomas A. Gandy Sr. / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7504 Livingston Road Oxon Hill, Maryland 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Vets. Cemetery
Date: 07/18/2001
20c. Location - City or Town, State: Cheltenham, Md.

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, of complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA OF THE LUNG — Approximate Interval: MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D19431
29d. Date signed (Month, Day, Year): 7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank M. Sparrow MD 1170 Professional Pl #205 Ft Wash MD 20744

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#25 perPHYG798 8/22/01 EW

Certificate of Death

Reg. No. 2001 24146

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IVY M. GRAY

2. Date of Death Month Dey Yeer: July 10, 2001

3. Time of Death: 12:50 AM

4e Facility Neme *(If not institution, give street end number)*: Fox Chase Nursing Home

4b. City, Town, or Location of Death: Silver Spring

4c. County of Deeth: Montgomery, Co.

Funeral Director

5. Social Security Number: 578-52-3218

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 10, 1938

9. Birthplace *(State or Foreign Country)*: Wash. D.C.

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7619 Oxman Road

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondary (0-12) / College (1-4or 5+): 2-Years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: Henry C. Sutton

18. Mother's Name *(First, Middle, Maiden Surneme)*: Ester Pollard

19a. Intormant's Name/Raletionship *(Type, Print)*: Pam E. Gallion (Daughter)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2378 Anvil Lane Temple Hills, Maryland 20748

20e. Methed ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, crametory or other place)*: Arlington Nat Ceme.

Dete: 7-19-2001

20c. Location - City or Town, State: Arlington, Va.

21. Signeture of Funeral Service Licensee: Wilmer R. Stum

22. Name end Address of Feclity: Columbia Heights Funeral Home 3605-14th Street, N.W. Wash., D.C. 20010

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode ot dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)
e. STROKE — INSTANT

Due to (or es a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events rasulting in death) Last
b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STROKE

DECUBITUS ULCER - GLUTEAL

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case refarred to medical examinar? 1☐ Yes 2☒ No

26. Plece ot Death *(Check only ona)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be detarmined

28a. Data ot Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece ot Injury - At home, term, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ Certifying Physician: To the best ot my knowledge, deeth occurred at the time, date and plece, end due to tha ceuse(s) end mennar as stated. 2☐ Medical Examiner: On tha basis of examinetion end/or investigation, in my opinion, daath occurred et the time, data end plece, end due to tha causa(s) end manner stated.

29b. Signeture and title of certifier:

29c. License number: D 28656

29d. Date signed *(Month, Dey, Year)*: JULY, 16, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): RAVI VASSI MD 8609 SECOND AVENUE, #Silver Springs

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 19 2001

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Earl Glasgow, Sr.

2. Date of Death Month: July Day: 16 Year: 2001

3. Time of Death: 2340

4e. Facility Name *(If not institution, give street and number)*: Anne Arundel Gen. Hosp

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: A Arundel

Funeral Director

5. Social Security Number: 577 32 9516

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthdey)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: March 1,1929

9. Birthplace *(State or Foreign Country)*: Washington D.C.

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 228 Paula Lynn Drive

10f. Zip Code: 20904

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1 [ ] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion *(Specify only highest grede completed)*: Elemantary/Secondary (0-12): 12 / Collega (1-4or 5+): 0

18a. Dacedant's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Self Employed

16b. Kind of Business/Industry: Meat Company

17. Father's Neme *(First, Middle, Last)*: Augustus Rossell Glasgow, Sr.

18. Mother's Nama *(First, Middla, Maiden Surname)*: Lena Josephine Scheuch

19a. Informent's Neme/Reletionship *(Type, Print)*: Son William Earl Glasgow, Jr.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 2545 Arbor Court Davidsonville Maryland 21035

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lakemont Memorial Gardens

Date: July 20,2001

20c. Location - City or Town, Stete: Davidsonville MD

21. Signeture of Funeral Service Licensee: Michael L Bigler

22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final diseesa or condition resulting in death) e. Arteriosclerotic Heart Disease

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara eutopsy findings eveileble prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Phyaician:** To the best of my knowladge, deeth occurred et the time, dete and plece, end due to the ceusa(s) end menner es stated. 2 [X] **Medical Examinar:** On the basis of axamination end/or investigation, in my opinion, daath occurred et the time, data and place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: William P Jones Deputy

29c. License number: D 06054

29d. Date signed *(Month, Dey, Yeer)*: 7/18/01

30. Nema end eddrass of person who completed cause of death (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUL 19 2001

32. Registrar's Signeture: P. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24148

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Marshall Green
2. Date of Death Month Dey Year: July 13, 2001
3. Time of Death: 8:32 pm
4e. Facility Name *(If not institution, give street end number)*: 2228 Penfield Lane
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 219-12-4969
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 73 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Sept. 10, 1927
9. Birthplace *(Stete or Foreign Country)*: Arkansas

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2228 Penfield Lane
10f. Zip Code: 20718
10g. Citizen of Whet Country?: U.S.A.
11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☐ No If Yes, Give Yaer or Datas: VIETNAM
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Flyer Pilot
16b. Kind of Business/Industry: Air Force
17. Father's Neme *(First, Middle, Last)*: John Henry Green
18. Mother's Name *(First, Middle, Meiden Surneme)*: Tommie Neagel
19e. Informent's Neme/Reletionship *(Type, Print)*: Josepha Green - Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2228 Penfield Lane, Bowie, MD 20718
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Arlington National Cemetery
Date: 07/24/01
20c. Location - City or Town, Stete: Arlington, Virginia
21. Signature of Funeral Service Licensee: Robert L. May
22. Name end Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth): e. LUNG CANCER — 7 Months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Due to (or es a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurat Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the tima, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Gerardo M. Gacad

29c. License number: D17799

29d. Date signed *(Month, Day, Year)*: July 19, 2001

30. Nama and address of person who completed ceusa of deeth (Item 23a) (Type, Print): Gerardo Gacad, M.D., 6510 Kenilworth Avenue, #2700, Riverdale, MD 20737

State Registrar

31. Dete filed *(Month, Dey, Year)*: JUL 20 2001

32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Victor Vernon Grayson	7	13	01	1:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hospital	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplece (State or Foreign Country)
232-26-1686	1☒M 2☐F	92 Yrs.			June 4, 1909	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Taneytown	1☐Yes 2☒No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
5030 Middleburg Rd.	21787	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		farmer	dairy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Martin C. Grayson	Arletta Fazenbaker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary M. Grayson/ wife	5030 Middleburg Rd. Taneytown, MD 21787

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	All County Crem.Serv.	7/15/01	Sykesville, MD

21. Signature of Funeral Service Licensee: Catherine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 6 E. Broadway Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceus ed the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	DAYS
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. AORTIC STENOSIS	YEARS
	Due to (or as e consequence of):	1.
	c. ATHEROSCLEROTIC CORONARY HEART DISEASE	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

ESSENTIAL HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
Vincent J. Fiocco MD	D01663	7/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VINCENT J. FIOCCO JR, 906C WASHINGTON RD WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
JUL 17 2001	Jenna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Yaar	3. Tima of Death
DAVID AUBREY GROSSNICKLE	JULY 12, 2001	1:55 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Daath
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-05-6058	1 [X] M 2 [ ] F	82 Yrs.			March 17, 1919	Maryland

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Frederick	Frederick	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
6128 Quinn Orchard	21701	U.S.A.

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - Amarican Indian, Black, White, atc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yas 2 [ ] No If Yas, Giva Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	18b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Cab Driver	Transportation

17. Father's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
Clay Vernon Grossnickle	Annie L. Morgan

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code)
Dolores Grossnickle (Wife)	6128 Quinn Orchard, Frederick, MD 21701

20a. Method of Disposition	20b. Placa of Disposition (Nama of cematary, cramatory or othar placa) / Data	20c. Location - City or Town, Stata
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Mount Olivet Cemetery 7/16/01	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robt E. Dailey	ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

		Approximate Intarval Between Onsat and Daath
Immediata Cause (Final disease or condition resulting in death)	a. Septic Shock	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Aspiration Pneumonia	2 days
	c. Due to (or as a consequence of): Dementia	
	d. Due to (or as a consequanca of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yas, outcoma of pregnancy	23d. Data of dalivary Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Othar (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Diabetes Mellitus

CAD

23a. Did tobacco usa contributa to tha causa of daath?	24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to completion of cause of daath?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [ ] No	1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Daath (Check only one)	
1 [ ] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined		M	1 [ ] Yes 2 [ ] No	
	28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)			28f. Location (Straat and Number or Rural Route Numbar, City or Town, Stata)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to tha causa(s) and mannar as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurrad at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ C. Helinski M.D.	D36119	7/12/01 530PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

170 Thomas Johnson Drive Frederick, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
JUL 16 2001	▶ Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Time of Death
JOAN	A.	GLADHILL	July 13, 2001	7:00 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11054 Powell Road	thurmont	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-42-1722	1☐ M 2☒ F	59 Yrs.			April 11,1942	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Frederick	Thurmont	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11054 Powell Road	21788	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ralph H. Bowlus	nellie Lapole

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Luther O. Gladhill / spouse	11054 Powell Rd./ Thurmont, Maryland 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resthaven Mem. Gardens.	07/16/01	Frederick,Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike/ Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	~8hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atypical Diabetes
hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
Francis E Becker MD	D30496	7/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E Becker MD; 300 W 7th St; Frederick MD 21701

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	Penny B Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24152

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Floyd Lamar Gladhill

2. Date of Death Month Dey Year: July 16, 2001

3. Time of Death: 8:20 PM

4a Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-18-2487

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 1, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 201 Linden Boulevard

10f. Zip Code: 21769

10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Officer

16b. Kind of Business/Industry: Gladhill Furniture Co.

17. Fether's Neme *(First, Middle, Last)*: Calvin T.K. Gladhill

18. Mother's Nama *(First, Middle, Maiden Surname)*: Lola Wiles

19e. Informent's Neme/Reletionship *(Type, Print)*: Alicia Gladhill (Daughter)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1216 North Market Street, Frederick, MD 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Zion Lutheran Cemetery

Deta: 7/19/01

20c. Location - City or Town, State: Middletown, Maryland

21. Signature of Funeral Service Licensee ▶ Robert E. Dailey

22. Name end Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failura. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. Pneumonia — 13 days

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Aspiration Pneumonia

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Coronary Artery Disease Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes casa refarred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the tima, data and place, end dua to the cause(s) end mennar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data end pleca, end dua to the ceuse(s) and manner steted.

29b. Signature and title of certifier ▶

29c. License number: D47651

29d. Dete signed *(Month, Dey, Year)*: 7-17-01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Asuncion M.D. 1564 Opossumtown Pike Frederick MD 21702

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 18 2001

32. Registrar's Signeture ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-3801-031
CJ
Chong Kol Hyon

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24153

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Chong Kul Hyon
2. Date of Deeth — Month: July; Dey: 07; Year: 2001
3. Time of Death: 06:35 P.M.
4a. Facility Nama *(If not institution, giva street and number)*: 14821 Cross River Court
4b. City, Town, or Location of Death: Silver Spring
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 231-31-5565
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 39 Yrs. — If Under 1 Year: Months / Deys; If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Dec 4, 1961
9. Birthplace *(Stete or Foreign Country)*: Korea

Usual Residence of Decedent

10a. Stete: VA
10b. County: Fairfax
10c. City, Town or Location: Alexandria
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 6860 Dear Run Dr.
10f. Zip Code: 22306
10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Dacedent Ever in U,S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Give Yaar or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade complatad)*: Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT usa retired)*: Auto Technician
16b. Kind of Business/Industry: Automobile

17. Father's Neme *(First, Middle, Last)*: Pyong Kun Hyon
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Pyong Ok Yu

19a. Informant's Name/Reletionship *(Type, Print)*: Chom S. Choe
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6860 Dear Run Dr., Alexandria, Va 22306

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Mt. Comfort — Dete: Jul 13, 2001
20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: Diana L. Serra
22. Nama and Address of Facility: Demaine Funeral Home, 5308 Backlick Rd., Springfield, Va 22151

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Contact Gunshot Wound to Head
Due to (or es e consequence of):
b.
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings eveileble prior to completion of cause of daath? 1☒ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar *(Specify)* Scene
27. Menner of Deeth: 1☐ Naturel 2☐ Accident 3☒ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*: 7/7/01
28b. Time of Injury: 4:45 P M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject shot self
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: residence
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: 14821 Cross River Street Silver Spring, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es stated. 2☒ **Medical Examiner:** On the basis of exeminetion and/or invastigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: J. M. Tidy
29c. License number: O.C.M.E.
29d. Data signed *(Month, Day, Year)*: July 8, 2001

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): JACK M. TIDY, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Dey, Year)*: JUL 16 2001
32. Registrer's Signetura: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Myron G. Hait, Jr.	July 14, 2001	2:15A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5223 Palco Place	College Park	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
117-16-6022	1 X M 2 F	74 Yrs.			July 7, 1927	Florida

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	College Park	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5223 Palco Place	20740	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1945-1954	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Analyst/Cryptologist	National Security Administration

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Myron Hait	Gladys Burnham

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Marjorie K. Hait - Wife	5223 Palco Place College Park, Maryland 20740

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)	Gate of Heaven Cemetery	7/17/01	Silver Spring, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald V. Borgwardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Non-Hodgkin's Lymphoma	15 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or es a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery (Month, Day, Year)
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1 ☐ Yes 2 X No 3 ☐ Probebly 4 ☐ Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)	
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.	
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner stated.	

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kai-Yiu Yeung	D/47310	July 14, 2001

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)
Kai-Yiu Yeung, M.D. 7525 Greenway Center Drive, #215 Greenbelt, Maryland 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Mary	Emma	Hancock	July 14, 2001	9:00A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-62-6727	1☐M 2☒F	85 Yrs.			Jan. 11, 1916	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Upper Marlboro	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6212 Buttercup Lane	20772	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th	N/A	Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George T. Van Pelt	Emma Hill

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy J. Hancock (Daughter)	6212 Buttercup Lane Upper Marlboro, Maryland 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) Date: July 19, 2001	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Washington National Cemetery	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	4 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D-18545	JULY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. WISOTSKY MD 12070 OLD LINE CENTER WALDORF, Md 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

To be completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Expired @ 836 A.m.

Hancock, mary

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24156

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gayle Robin Hamilton
2. Date of Death Month Day Year: July 17, 2001
3. Time of Death: 1:05 am
4a. Facility Name *(If not institution, give street and number)*: 10504 Meadowlake Terrace
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 003-32-3284
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 26, 1941
9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: Virginia
10b. County: Arlington
10c. City, Town or Location: Arlington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1000 North Arlington Mill Road
10f. Zip Code: 22205
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Professor
16b. Kind of Business/Industry: George Mason University

17. Father's Name *(First, Middle, Last)*: Marshall William Hamilton
18. Mother's Name *(First, Middle, Maiden Surname)*: Eva May Nunnelley

19a. Informant's Name/Relationship *(Type, Print)*: Nanci Hamilton-Hoffman - Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1828 Wagon Wheel Circle, Tallahassee, FL 32311

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 07/18/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer — 6 Months

Due to (or as a consequence of):
b. Cardio Pulmonary Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* Friend's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0022696
29d. Date signed *(Month, Day, Year)*: July 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore Watkins, M.D., 8238 Georgia Avenue, Silver Spring, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Submit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SELMA HIRSCH

2. Date of Death (Month, Day, Year): JULY 13, 2001

3. Time of Death: 12:40am

4a. Facility Name (If not institution, give street and number): HebrewHome of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 150 30 0763

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 18 1907

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: New Jersey

10b. County: Bergen

10c. City, Town or Location: Westwood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 500 Center Avenue

10f. Zip Code: 07602

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator

16b. Kind of Business/Industry: Grammar School

17. Father's Name (First, Middle, Last): Isidor Gersten

18. Mother's Name (First, Middle, Maiden Surname): Gussie Taub

19a. Informant's Name/Relationship (Type, Print): Norman Hirsch/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Romopock Court Mahwah, New Jersey 07430

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 7/14/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: National Funeral Home, 7482 Lee Highway Falls Church, Virginia 22042

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SYSTOLIC HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D18084

29d. Date signed (Month, Day, Year): July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24158

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William F. Happel

2. Date of Death — Month: July; Day: 18; Year: 2001

3. Time of Death: 12:05 p.m.

4a Facility Name *(If not institution, give street and number)*: Stella Maris Inc.

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-5032

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 6, 1915

9. Birthplace *(State or Foreign Country)*: Baltmore, MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltmore

10c. City, Town or Location: Baltmore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8809 Lakewood Road

10f. Zip Coda: 21134

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No — If Yas, Giva Yaar or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)* — Elementery/Secondery (0-12): 12; Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Personal Technichian

16b. Kind of Business/Industry: Federal Goverment

17. Fathar's Nama *(First, Middla, Last)*: Frederick W. Happel

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Mary R. Riehl

19a. Informant's Name/Raletionship *(Type, Print)*: Nancy Hilsher - Niece

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Coda)*: 8809 Lakewood Road Baltmore, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar piece)*: Fort Lincoln Cemetery

Data: 7-21-01

20c. Location - City or Town, Stata: Brentwood, MD

21. Signatura of Funaral Service Licensaa: Alfred Miller

22. Nama and Addrass of Facility: Gasch's Funeral Home P.A. 4739 Baltmore Avenue Hyattsville, MD 20782

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that causad tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart tailura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. End Stage Dementia

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa ratarrad to medical examinar? 1☐ Yas 2☐ No

26. Placa of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 8☐ Othar *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, tarm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)* 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, date and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at the time, date and piece, and due to the causa(s) and manner stated.

29b. Signatura and title of certifier: Mahany

29c. Licansa number: D0057727

29d. Data signed *(Month, Day, Year)*: July 20, 2001

30. Nama and addrass of parson who completed cause of death (Item 23a) (Typa, Print): 201-109 Bac River Neck Raod Baltmore, Maryland 21221

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 2 0 2001

32. Registrar's Signatura: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24159

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janice Denise Hyson

2. Date of Death — Month: July; Day: 12; Year: 2001

3. Time of Death: 3:00 AM

4a. Facility Name *(If not institution, give street and number)*: 10247 Prince Pl.

4b. City, Town, or Location of Death: Largo

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212-76-9029

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 43 Yrs.

If Under 1 Yaar — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: 01-12-1958

9. Birthplaca *(Stata or Foraign Country)*: South Carolina

Usual Residenca of Decedent

10a. Stata: MD

10b. County: Prince George's

10c. City, Town or Location: Largo

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street snd Number: 10247 Prince Pl. Apt. #T-1

10f. Zip Coda: 20774

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 1Yr

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Office Manager

16b. Kind of Businass/Industry: Private

17. Father's Nama *(First, Middla, Last)*: Walter B. Jackson

18. Mother's Nama *(First, Middle, Maiden Surnama)*: Dorothy McGowens

19a. Informant's Name/Ralationship *(Type, Print)*: Dorothy Jackson/Mother

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 7814 Allendale Dr. Landover, MD 20785

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cametary, cramatory or othar placa)*: Riverdale Crematory

Data: 7/17/01

20c. Location - City or Town, Stata: Riverdale, MD

21. Signature of Funeral Service Licensee: K. Wilson

22. Nama and Addrass of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwaan Onset and Death

Immediate Cause (Final disaasa or condition resulting in daath)

e. Cardiopulmonary Arrest

Dua to (or as a consaquanca of):

b. Malignant Melanoma

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiatad avants resulting in daath) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Rasidence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*:

28b. Tima of Injury:

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describa how injury occurrad:

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*:

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladge, death occurrad at the time, data and placa, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data snd placa, and due to tha cause(s) and mannar stated.

29b. Signature and Title of certifiar:

29c. Licansa number: D0022696

29d. Data signed *(Month, Day, Year)*: 7/19/01

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): 8238 THEODORE GEORGIA WATKINS AVE, Silver Spring MD 209101

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 20 2001

32. Registrar's Signatura: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the daath cartificata be axacutad within 24 hours aftar death.

To the Funeral Director: Aftar this cartificata has been signed by the attending physician and completely filled in by tha funaral director, page 2 should be datachad for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24160

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harold Vincent Hausler

2. Data of Death — Month: July Day: 14 Year: 2001

3. Time of Death: 1250am

4a. Facility Name *(If not institution, give street and number)*: 931 Seminole Road

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-18-2212

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Jul 03, 1920

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residence of Decadant

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 931 Seminole Road

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decadent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decadant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): — Collega (1-4or 5+): 2 Trade

16a. Decadent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Foundry Supervisor

16b. Kind of Businass/Industry: Metallurgy

17. Fathar's Nama *(First, Middla, Last)*: Gottlieb Hausler

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Rosa Clara Wickless

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs Catherine King Hausler/Wife

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 931 Seminole Road, Frederick, Maryland 21701

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or othar placa)*: Mt Olivet Cemetery — Data: Jul 18, 2001

20c. Location - City or Town, Stata: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kathleen A Beeson M00706

22. Nama and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximata Interval Batwaen Onset and Death

Immediate Cause (Final disaasa or condition resulting in deeth)
a. Pulmonary Fibrosis — Approximata Interval: yrs
Due to (or as a consequanca of):
CHF

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last
b. Due to (or as a consequanca of):
c. Aortic stenosis
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to complation of cause of deeth? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residanca 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)* — 28b. Tima of Injury — M — 28c. Injury at Work? 1☐ Yas 2☐ No — 28d. Describe how injury occurrad

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, death occurred at tha time, data and placa, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Helinski MD

29c. Licansa number: D36119

29d. Data signed *(Month, Day, Yaar)*: 7/16/01

30. Nama and address of person who complatad causa of daath (Item 23a) (Type, Print): Christine Helinski, M.D., 170 Thomas Johnson Dr, Suite 100, Frederick, MD21702

State Registrar

31. Data filed *(Month, Day, Yaar)*: JUL 16 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#19a per FH FCHD,KS **Certificate of Death** 7/19/2001 Reg. No. 2001 24161

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Franklin Hale
2. Date of Death: Month July Day 17 Year 2001
3. Time of Death: 3:40 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-24-5978
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 15, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Jefferson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3665 Point of Rocks Road
10f. Zip Code: 21755
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): self
16b. Kind of Business/Industry: excavating/ plumbing/heating

17. Father's Name (First, Middle, Last): Silas Franklin Hale
18. Mother's Name (First, Middle, Maiden Surneme): Mabel Virginia Merchant

19a. Informant's Name/Relationship (Type, Print): Dora Woods Hale ~~Dora Woods Dale~~, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3665 Point of Rocks Road, Jefferson, MD 21755

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Jefferson Methodist Cem. Dete 7/19/2001
20c. Location - City or Town, Stete: Jefferson, Maryland

21. Signature of Funeral Service Licensee: [signature] M00999
22. Name end Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Granulocytopenia Sepsis	7d
Due to (or as a consequence of): b.	Chemotherapy	14d
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as e consequence of): c.	Transitional Cell Carcinoma	
d.	bladder - metastatic	2 mo

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated. 2 [ ] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D14C 26
29d. Date signed (Month, Day, Year): July 17, 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): JG Rausch MD, 501 W 7th St, Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24162

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MAURICE JOSEPH HEARNE
2. Dete of Deeth — Month: JULY Dey: 15 Yeer: 2001
3. Time of Death: 7:10 AM
4e. Feclity Neme (If not institution, give street and number): VILLA ROSA NURSING HOME
4b. City, Town, or Location of Deeth: Mitchellville
4c. County of Deeth: Prince Georges

Funeral Director

5. Sociel Security Number: 321-01-3335
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): March 24, 1911
9. Birthplece (State or Foreign Country): Illinois

Usuel Residence of Decedent

10a. State: New Hampshire
10b. County: Hillsborough
10c. City, Town or Location: Milford
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 77 Quarry Cr
10f. Zip Code: 03055
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): College (1-4or 5+): 3
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Management
16b. Kind of Business/Industry: Oil Company
17. Fether's Neme (First, Middle, Last): Maurice Hearne
18. Mother's Neme (First, Middle, Maiden Surname): Mary Shea
19e. Informent's Neme/Reletionship (Type, Print): William S. Hearne son
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1320 N. Veitch St. Arlington, VA 22201
20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Dete: 7/21/01
20c. Location - City or Town, Stete: Suitland, Md.
21. Signeture of Funerel Service Licensee: [signature] MG1141
22. Neme end Address of Feclity: Everly-Wheatley Funeral Home 1500 W Braddock Rd., Alexandria, Virginia

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or resptretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth): e. CONGESTIVE HEART FAILURE

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest:

b. HEART DISEASE

Due to (or es e consequence of):

c. HYPERTENSION

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings evellable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒**Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the basis of exemtnetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature]
29c. License number: D0050951
29d. Dete signed (Month, Dey, Yeer): July 15th 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 6510 KENILWORTH AVENUE RIVERDALE MD 20737

State Registrar

31. Dete filed (Month, Dey, Yeer): JUL 31 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the etteneing physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Amended #29c, mlo, 7/17/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
WILLIAM W. HOGAN			July	10	2001	7:40 a.M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
Garrett Memorial Hospital	Oakland		Garrett			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
096-05-4545	1[X] M 2[ ] F	88 Yrs.					Nov. 5, 1912	CT

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Keyser	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
500 Carskadon Lane Apt. 814	26726	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WW II	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Crimes News Reporter	Newspaper

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William D. Hogan	Loretta Cummiskey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William C. Hogan/Son	105 E. 1st Avenue Mt. Lake Park, MD 21550

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	St. Thomas Cemetery	July 12 2001	Keyser, WV

21. Signature of Funeral Service Licensee: ▶ Brian L. Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Atherosclerotic Vascular Disease	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Roger Lewis MD	MD D00965 63 W.Va 12705	7/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger Lewis, M.D. 603-B West State Avenue Terra Alta, WV 26764

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 12 2001	Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linda Mae Jackson

2. Date of Death: Month July Day 4 Year 2001

3. Time of Death: 18:10 PM

4a. Facility Name (If not institution, give street and number): THE Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 235-68-8939

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 15, 1943

9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1406 Owens Road

10f. Zip Code: 20745

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Personnel Specialist

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Daniel D. Jackson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary F. Taylor

19a. Informant's Name/Relationship (Type, Print): Marla McRae / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1406 Owens Road, Oxon Hill, MD 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 7/9/01

20c. Location - City or Town, State: Bolivar, W. Virginia

21. Signature of Funeral Service Licensee: Larry L. Simmons

22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike, Forestville, MD 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asystolic Arrest — 15 Minutes

Due to (or as a consequence of):

b. Metastatic Breast Cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Respiratory failure — 15 Minutes

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Hamlette MD

29c. License number: RE5000

29d. Date signed (Month, Day, Year): July 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Hamlette, M.D. 600 North Wolfe Street Baltimore, Md 21287

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sallie A. Jones	July 14, 2001	12:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-30-6276	1☐ M 2☒ F	79 Yrs.			8/15/21	N. Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.	N/A	Washington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5215 Jay St., N.E.	20019	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		Dietary Worker	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Julius Best	Emma Whites

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Geneva Williams/Step-daughter	4503 Howe Ave., Suitland, Md. 20746

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Nat'l. Mem. Park	7/20/01	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Gary W. Pratt	H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Artery Disease

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Diabetes

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Salvador Sylvester, DO	H00559 27	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Aubrey Johnson
2. Date of Death Month: 07 Day: 15 Year: 2001
3. Time of Death: 6:20 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-10-4031
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1914
9. Birthplace (State or Foreign Country): Wash., DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4701 - 12th St., N.E.
10f. Zip Code: 20017
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Clerk
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Charlie Johnson
18. Mother's Name (First, Middle, Maiden Surname): Zura Lee

19a. Informant's Name/Relationship (Type, Print): Kathy L. Johnson - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4701 - 12th St., N.E. Wash., D.C. 20017

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Cemetery
Date: July 19, 2001
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Cancer of the Prostate — 9 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wesley B. Mason, MD
29c. License number: D 22235
29d. Date signed (Month, Day, Year): 7/15/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wesley B. Mason, 10810 Connecticut Ave, Kensington, MD, 20895

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: D. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

LEOPOLD MANION JUICO
01-3933-017
RDC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leopold Manion Juico

2. Date of Death: Month JULY Day 16 Year 2001

3. Time of Death: 00:15 AM

4a. Facility Name (If not Institution, give street and number): ROUTE 231 SOUTH OF ROUTE 5

4b. City, Town, or Location of Death: HUGHESVILLE

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 360-48-4076

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 37 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 8, 1964

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland 10b. County: Calvert 10c. City, Town or Location: St. Leonard 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5640 Eucalyptus Street 10f. Zip Code: 20685 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Fillipino

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Residential

17. Father's Name (First, Middle, Last): Leopoldo Juico

18. Mother's Name (First, Middle, Maiden Surname): Marion Manion

19a. Informant's Name/Relationship (Type, Print): Stacey L. Juico (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5640 Eucalyptus Street St. Leonard, Maryland 20685

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Lee Crematory Date: July 20, 2001

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 7/15/01

28b. Time of Injury: 1057 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Drive in auto accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): RTE 231 / RTE 5

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): JULY 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tilton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signature: ▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#5 PR. INFMT. G798 8-23-01 JAB

Certificate of Death

Reg. No. 2001 24168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marie Carrie Jordan	JULY 16, 2001	8:45AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
126-05-7948 ~~027-09-5162~~	1☐M 2☒F	93 Yrs.			Dec. 6,1907	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Camp Springs	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6208 Davis Blvd.	20746	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married ☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	N/A	Accounting Clerk	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alvin Kreglosi Long	Carrie Maggie Grieser

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20650
Frances A. Greene (POA)	40987 Lake And Brentan View Dr. Leonardtown MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill Cemetery	July 20, 2001	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Louis L. Lee	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD20735

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Failure — minutes

Due to (or as a consequence of):

b. Acidosis ? — hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Aspiration Pneumonia — hrs

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jarboe MD	D 06419	7-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JAMES JARBOE HOLLYWOOD ,MD. 20636

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME: MARIE JORDAN

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24169

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Linda Ernestine Brown Kovacs

2. Date of Death Month / Day / Year: July 11, 2001

3. Time of Death: 9:27 P.M.

4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-74-3534

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 48 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 13, 1952

9. Birthplace *(State or Foraign Country)*: Washington,D.C.

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1479 Bruce Place, S. E.

10f. Zip Coda: 20020

10g. Citizen of Whet Counlry?: United States

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada complated)*: Elementary/Secondary (0-12): 12th grade | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Custodian

16b. Kind of Business/Industry: Architect of the Capitol

17. Fathar's Nama *(First, Middla, Last)*: Ernest Atkerson Brown, Sr.

18. Mothar's Name *(First, Middle, Maiden Surnama)*: Ola Helen Ferris

19a. Informant's Neme/Relationship *(Type, Print)*: (Brother) Ernest Atkerson Brown,Jr.

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5617 Onslow Way; Capitol Heights, Maryland 20743

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: George Washington Cemetery | Date: July 21,2001

20c. Location - City or Town, Stata: Adelphi, Maryland

21. Signatura of Funaral Sarvice Licensee: Kavanagh Chapel

22. Nama and Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. ANOXIC ENCEPHALOPATHY — months

Dua to (or as a consequance of):

b. DISSECTED DESCENDING AORTIC ANEURYSM — months

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa given in Part I.

RESPIRATORY FAILURE

VENTILATOR DEPENDENT

PNEUMONIA HYPERTENSION

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of ceusa of death? 1☐ Yas 2☐ No

25. Was cesa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, death occurred at the time, data and plece, end dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar statad.

29b. Signatura and title of certifiar: Paul A. DeVore MD

29c. License number: D01852

29d. Data signed *(Month, Day, Year)*: JULY 12,2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): PAUL A. DEVORE MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24170

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sally Elizabeth Kropp
2. Date of Death Month / Day / Year: July 16, 2001
3. Time of Death: 3:10 PM

4a. Facility Name *(If not institution, give street and number)*: Larkin Chase Nursing Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 168-18-8767
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 19, 1908
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: PA.
10b. County: Luzerne
10c. City, Town or Location: Wilkes-Barre
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 215 High St. , Apt. 709
10f. Zip Code: 18702
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales clerk
16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Joseph Semokaitis
18. Mother's Name *(First, Middle, Maiden Surname)*: Matilda Sruogonis

19a. Informant's Name/Relationship *(Type, Print)*: Charles R. Kropp son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2412 Keyberry Lane, Bowie, Md. 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gethsemane Cemetery | Date: 07-20-01
20c. Location - City or Town, State: Easton, PA.

21. Signature of Funeral Service Licensee: Donald W. Beall
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End stage Alzheimer's disease	6 mos.
	Due to (or as a consequance of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cardiac arrythmia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald W. Beall
29c. License number: D-34525
29d. Date signed *(Month, Day, Year)*: July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. J. Rao MD, 4000 Mitchellville Rd., Bowie, Md. 20716

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Timothy J. Kearney
2. Date of Death (Month, Day, Year): July 17, 2001
3. Time of Death: 11:40 PM
4a. Facility Name (If not institution, give street and number): 12925 Marquette Lane
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 047-26-4592
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 19 1935
9. Birthplace (State or Foreign Country): Conn.

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12925 Marquette Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1954-1957
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales-Specialty Shop
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Timothy J. Kearney
18. Mother's Name (First, Middle, Maiden Surname): Winifred Tirendi

19a. Informant's Neme/Reletionship (Type, Print): Kenneth M. Kearney (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1259 Delaware Ave. Churchton, MD 20733

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.
Date: 7/23/01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Richard Rendon
22. Name and Address of Facility: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
a. Renal Cell Cancer
Due to (or as a consequence of):
b. Metastases of Cancer to Brain

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [XX] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neylich M.D.
29c. License number: D0050619
29d. Date signed (Month, Day, Year): 7/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11340 Pembrooke Square, Suite 201, Waldorf, MD 20603

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24172

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise Kline

2. Date of Death: Month July Day 16 Year 2001

3. Time of Death: 1 45 AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-26-1501

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 926 Shawnee Drive

10f. Zip Code: 21701

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Wilbur F. Sheffield

18. Mother's Name (First, Middle, Maiden Surname): Cora E. Geisinger

19a. Informant's Name/Relationship (Type, Print): Charles Kline/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6573 Prestwick Drive Highland, MD 20777

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place): Mt. Olivet Cemetery

Date: July 20, 2001

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Due to (or as a consequence of): — 1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William Flowers MD

29c. License number: D20789

29d. Date signed (Month, Day, Year): July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Flowers MD 11055 Little Patuxent Columbia MD

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

10 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EULAH FAYE KIFER
2. Date of Death (Month, Dey, Year): JULY 11, 2001
3. Time of Death: 23:55
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 205-42-1790
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): MAY 17 1918
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: PA.
10b. County: BEDFORD
10c. City, Town or Location: ARTEMAS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 340 LASHLEY ROAD
10f. Zip Code: 17211
10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): BRUCE COLLINS
18. Mother's Name (First, Middle, Maiden Surname): EMMALINE IMES

19a. Informent's Name/Relationship (Type, Print): SHELBY ROBINSON DAUGHTER
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 160 BIG CREEK ROAD ARTEMAS PA 17211

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SUNSET CEMETERY
Date: JULY 15 2001
20c. Location - City or Town, Stete: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	CEREBRAL VASCULAR ACCIDENT	1 day
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	HYPERTENSION	>5 years
Due to (or as a consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.: ATRIAL FIB, GASTROINTESTINAL BLEEDING, S/P PACEMAKER, RIGHT CAROTID STENT

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deth (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Shiv Khanna
29c. License number: D0054004
29d. Date signed (Month, Day, Year): 7, 12, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): DR SHIV C. KHANNA 625 KENT AVENUE CUMBERLAND MARYLAND 21502

State Registrar

31. Dete filed (Month, Day, Year): JUL 13 2001
32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24174

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Geraldine King

2. Date of Death Month / Day / Year: JULY 13 2001

3. Time of Death: 11:15 P.M.

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-20-5771

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul 9, 1926

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Fort Ashby

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: Country Villa Apartments Apt. 119

10f. Zip Code: 26719

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Laundry

17. Father's Name *(First, Middle, Last)*: Clem Robinette

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie (Bartik)

19a. Informant's Name/Relationship *(Type, Print)*: Kathy Brown daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: HC 86 Box 41A;Fort Ashby WV 26719

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rocky Gap Veterans Cem

Date: 7/16/2001

20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NACROTIZING FASCITIS — 1 MONTH

Due to (or as a consequence of):

b. DIFFUSE MICRO VASCULAR DISEASE — 2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS - HYPERPARTHROIDISM SECONDARY TO CHRONIC RENAL FAILURE, DIABETIC NEPHROPATHY CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N.A. Ranjithan

29c. License number: D19318

29d. Date signed *(Month, Day, Year)*: July 16th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. N.A. RANJITHAN, 517 OLDTOWN ROAD, CUMBERLAND, MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001

32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6

TMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24175

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eleanor Marie Kirtley

2. Date of Death: Month July, Day 15, Year 2001

3. Time of Death: 3:30 p.m.

4a. Facility Name *(If not Institution, give street and number)*: Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 216-30-1937

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 17, 1932

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 325 D Street

10f. Zip Code: 26726

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Kline

18. Mother's Name *(First, Middle, Maiden Surname)*: Lean Campbell

19a. Informant's Neme/Relationship *(Type, Print)*: Robyn K. Pochettino-daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 10516 Bill Lilly Court, Laurel, MD 20723

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, cremetory or other piece)*: Potomac Memorial Gardens

Dete: 7/18/01

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: ▶ Robert A. Schadler

22. Name and Address of Facility: Markwood Funeral Home, 111 S. Mineral Street, Keyser, WV 26726

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not anter tha moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG MASS — 1 YEAR

Due to (or as e consequence of):

Sequentially list conditions, it any, leading to immediete Ceuse. Enter Underlying Ceuse (Diseesa or injury that initiated events resulting in death) Last

b. Due to (or es e consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert t.: MULTIPLE SCLEROSIS, DIABETES MELLITUS, SEIZURE DISORDER; S/P PACEMAKER

23b. Dtd tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of tnjury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of tnjury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, daath occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Shiv Khanna

29c. License number: D0054004

29d. Date signed *(Month, Dey, Year)*: July 17, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Shiv Khanna 625 Kent Avenue, Suite 101 Cumberland, Maryland 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: ▶ Regina B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #23a &1 7/17/01 per Dr.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 24176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jeanne Ellen Lerch ~~Jeannie Lerch~~

2. Date of Death: Month July Day 15, Year 2001

3. Time of Death: 5:30A. M

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 519-26-3390

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 31, 1929

9. Birthplace (State or Foreign Country): Idaho

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 7414 Brenish Drive

10f. Zip Code: 20879

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Montgomery County School System

17. Father's Name (First, Middle, Last): Elvin Wilford Gottfredson

18. Mother's Name (First, Middle, Maiden Surname): Surena Julia Sorenson

19a. Informant's Name/Relationship (Type, Print): Jeanne E. Marlo - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13201 Taney Drive Beltsville, Maryland 20705

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mountain View Cemetery

Date: 7/21/01

20c. Location - City or Town, State: Pocatello, Idaho

21. Signature of Funeral Service Licensee: ▶ Donald V Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Recurrent Aspiration Pneumonia

Due to (or as a consequence of):
b. Pulmonary Embolus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Cerebrovascular Accident

Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jenny Y Moy M

29c. License number: D43260

29d. Date signed (Month, Day, Year): July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jenny Moy, M.D. 13952 Baltimore Avenue Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24177

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Chun Y. Lau	July 14, 2001	9:59 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
438-06-9609	1[X] M 2[ ] F	70 Yrs.			Oct. 20, 1930	China

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
600 East Randolph Road	20904	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Restaurant Owner	Food

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Man C. Lau	Yuk Lan Chow Lau

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lucia Lau - Daughter	600 E. Randolph Rd., Silver Spring, MD 20904

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Ridgeview Cemetery	July 20, 2001	Allen, TX

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Allen J. Woodall	Capitol Funeral Service, Inc. 7211 Lee Hwy., Falls Church, VA 22046

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Massive Myocardial Infarction	30 Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Arteriosclerotic Heart Disease	Years
	Due to (or as a consequence of): c. Hypertension	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Osteoarthritis with both knee replacements

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1[X] Yes 2[ ] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[X] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 8[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Bernadette Soongmo	D13550	7/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bernadette Soongmo 1104 Spring street #200 Silver spring md 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24178

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Lepley

2. Date of Death Month: July Day: 14 Year: 2001

3. Time of Death: 14:45

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-10-4722

6. Sex: 1☐M 2☐F — X

7. Age *(In yrs. last birthday)*: 90 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 16, 1911

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐Yes 2☐No — X

10e. Street and Number: 1526D Old Towne Manor

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married — X 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☐No — X *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Minister

16b. Kind of Business/Industry: Nazarene Church

17. Father's Name *(First, Middle, Last)*: Dalton Lepley

18. Mother's Name *(First, Middle, Maiden Surname)*: Cora unk

19a. Informant's Name/Relationship *(Type, Print)*: Rhea M. Lepley wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1526D Old Towne Manor;Cumberland MD 21502

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Memorial Par — Date: 7/17/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Encephalopathy — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gerd, Blindness, Degenerative joint disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Khanna

29c. License number: D0054004

29d. Date signed *(Month, Day, Year)*: July 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Shiv Khanna 625 Kent Avenue, Suite 101 Cumberland, Maryland 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24179

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN J. LONG

2. Date of Death Month Day Year: July 15, 2001

3. Time of Death: 2:12 pm

4a. Facility Name *(If not institution, give street and number)*: COUNTRY HOUSE RESIDENCE

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217-10-1908

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jun 11, 1906

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 15 Cumberland Street

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Board of Education

17. Father's Name *(First, Middle, Last)*: Peter H. Long

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie (Gorman)

19a. Informent's Name/Relationship *(Type, Print)*: Susan L. Clucas daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 319 Sunset Drive;Cumberland, MD21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SS Peter Paul Cemetery

Date: 7/18/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac failure — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Arteriosclerosis — 15 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Breza MD

29c. License number: D12532

29d. Date signed *(Month, Day, Year)*: 07/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Breza M.D. 912 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: Regina B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Medical Certification: To Be Completed by Physician/Medical Examiner

per: D. Barbus MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24180

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hattie Ann Mathis
2. Date of Death Month Day Year: July 6, 2001
3. Time of Death: 1:20 AM
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 36 2286
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 105 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 7, 1896
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: W. Virginia
10b. County: Jefferson
10c. City, Town or Location: Charlestown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 101 Beouregard Blvd.
10f. Zip Code: 25414
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Married 2☐Married ☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates: ☒
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes ☒No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Martin Simmons
18. Mother's Neme *(First, Middle, Meiden Sumame)*: Mary Grubbs

19a. Informant's Name/Relationship *(Type, Print)*: Richard B. Mathis , Jr. (SON)
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 101 Beouregard Blvd. Charlestown, West Virginia 25414

20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery — Date: July 12, 2001
20c. Location - City or Town, Stete: Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or es e consequence of):
b. ASCVD
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
c. SENILE DEMENTIA
Due to (or as e consequence of):
d.

Approximate Interval Between Onset end Death

IF FEMALE:
23b. Wes decedent pregnant in the pest 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and piece, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D27577
29d. Date signed *(Month, Day, Year)*: 7/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ophwell Cumberbatch M.D. 8416 Central Avenue Landover, Maryland 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 18 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
ORLANDO MATUTE		MAY 30, 2001	2:05 p M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
Holy Cross Hospital	Silver Spring	Montgomery	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
214-23-5335	1[X] M 2[ ] F	52 Yrs.			April 4, 1949	Nicaragua

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Montgomery	Rockville	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1345 Justice Road	20853	Nicaragua

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Yeer or Dates:	1[X] Yes 2[ ] No Specify: Nicaraguan	Specify: Other

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Unknown	Unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Hernan Matute	Lucia Cardnes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Mercedes Matute (Wife)	1345 Justice Road Rockville, Md. 20853

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1[X] Buriel 2[ ] Cremation 3[ ] Removel from State 4[ ] Donetion 5[ ] Other (Specify)	Norbeck Mem. Park	06-02-01	Olney, Md.

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
▶ Wanda C. Bacon CC0361	3447 14th St., N.W/ Bacon Funeral Home, Inc. Washington, D. C. 20010

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death)	a. Acute Myocardial Infarction	60 Min
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	a. Due to (or as e consequence of): Aspiration Pneumonia	
	b. Due to (or es a consequence of): Tracheal Obstruction	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Dete of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnency 4[ ] Pregnent et time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobecco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probebly 4[X] Unknown

24e. Was en autopsy performed? 1[ ] Yes 2[X] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was case referred to medical exeminer? 1[ ] Yes 2[X] No

26. Place of Death (Check only one): Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[X] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1[X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated.
2[ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Lawrence A Oufiero MD	D0019924	5-31-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lawrence Oufiero, M.D. 1500 Forest Glen Rd. Silver Spring, Md. 20901

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
JUL 18 2001	▶ Glenda G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas M. McGlynn
2. Date of Death: Month July Day 17 Year 2001
3. Time of Death: 8:53A M
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-42-3691
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 30, 1933
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2231 Pinefield Road
10f. Zip Code: 20601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1950-1953
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police (Lt. Harbor Master)
16b. Kind of Business/Industry: D.C. Metropolitan

17. Father's Name (First, Middle, Last): Thomas Patrick McGlynn
18. Mother's Name (First, Middle, Maiden Surname): Catherine M. McCann

19a. Informant's Name/Relationship (Type, Print): Barbara McGlynn (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2231 Pinefield Road Waldorf, Maryland 20601

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Trinity Memorial Gardens
Date: July 25, 2001
20c. Location - City or Town, Stete: Waldorf, Maryland

21. Signature of Funeral Service Licensee: Louis L. Grant m00257
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediete Cause (Finel disease or condition resulting in death)
a. Myocardial infarct
Due to (or as e consequence of):
b. Coronary artery disease
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Approximete Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time ot deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause ot death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2 ☐ **Medicat Examinar:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: T. Pace
29c. License number: D0022574
29d. Date signed (Month, Day, Yeer): 7/18/01
30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): Timothy R. Pace, M.D. 12070 Old Line Center#202 Waldorf, Md. 20602

State Registrar

31. Date filed (Month, Dey, Year): JUL 20 2001
32. Registrar's Signature: G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 16a PER FH G798 08/09/01 RR

Certificate of Death

Reg. No. 2001 24183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Francis Delbert McCarthy	July	18	2001	3:20PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6365 Ripley Road	La Plata	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-18-2312	1☒M 2☐F	78 Yrs.			June 29, 1923	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Charles	LaPlata	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6365 Ripley Rd.	20646	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1942-1969	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Sargent 1st CLASS ~~First Sargent~~	U.S. Army
12			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James R. McCarthy	Anna Stella Barbour McCarthy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Imogene A. McCarthy/Wife	P.O. Box 562 LaPlata,MD 20646

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Brinsfield-Echols Crem.	7/20/01	Charlotte Hall,MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David C. Echols M00945	AREHART-ECHOLS FUNERAL HOME, P.A. P.O. Box 567 LaPlata,MD 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Emphysema	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No XXX	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No XXX	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence XXX 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
XXX 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) XXX

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Krishan M. Mathur	D28352	July 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 9 2001	▶ Bernice D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24184

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sister Benedicta Madden
2. Date of Death Month Day Year: July 14, 2001
3. Time of Death: 10:20 P.M.
4a. Facility Name *(If not institution, give street and number)*: St. Vincent Care Center
4b. City, Town, or Location of Death: Emmitsburg
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-54-6045
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 98 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 19, 1903
9. Birthplace *(State or Foreign Country)*: Ireland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Emmitsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 335 South Seton Avenue
10f. Zip Code: 21727
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Elem/Sec. 0-12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Child Care
16b. Kind of Business/Industry: Religious Community Daughters of Charity

17. Father's Name *(First, Middle, Last)*: Patrick Madden
18. Mother's Name *(First, Middle, Maiden Surname)*: Bridget Fleming

19a. Informant's Name/Relationship *(Type, Print)*: Sister Camilla Harant
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 333 S. SEton Avenue, Emmitsburg, MD 21727

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. JOSEPH'S P. H.
Date: 7/19/01
20c. Location - City or Town, State: EMMITSBURG, MD

21. Signature of Funeral Service Licensee: John M. Skiles
22. Name and Address of Facility: SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD 21727

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 2 wks
Due to (or as a consequence of):
b. Atherosclerotic Heart Disease — >10 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Chronic Hypertension — > 20 years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Advanced Parkinsons Disease with Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Alan Carroll MD
29c. License number: D18705
29d. Date signed *(Month, Day, Year)*: 16 JULY 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001
32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
IRVIN SETH MANGES	July 13, 2001	0630 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-24-1772	1☒M 2☐F	73 Yrs.			JUNE 16 1928	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	CUMBERLAND	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20 HOMESTEAD AVENUE	21502	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1950-1956	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5	BOARD OF EDUCATION ALLEGANY CO.	TEACHER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
COBERN EVANS MANGES	IRENE ELSIE ATHEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BETTY MANGES WIFE	20 HOMESTEAD AVENUE CUMBERLAND MARYLAND 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	SUNSET CEMETERY	JULY 16 2001	CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dale L. Merritt	MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ventricular arrythmia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): acute Myocardial Infarction.	10 minutes or less.
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

acute Pneumonia. Atelectasis, COPD. Hypothyroidism. Dementia Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ SL Sandhir MD	D 14464	July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR SIKANDER SANDHIR, 48 TARN TERRACE, FROSTBURG, MD 21530

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 16 2001	▶ Jenna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

MU2 (IVH)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24186

LOUISE MARTIN 220-10-1710

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Louise	F.	Martin	JULY	11,	2001	22:30 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-10-1710	1☐M 2☒F	81 Yrs.					Aug 23, 1919	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2291 Shades Lane	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Raymond Donahue	Pearl (Ruby)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ralph C. Martin husband	2291 Shades Lane;Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sunset Memorial Park	7/14/2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial infarction	7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dilated ischemic cardiomyopathy

Severe aortic stenosis

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robustiano Barrera Jr	D0014865	JULY 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR ROBUSTIANO BARRERA 500 MEMORIAL AVE SUITE 201 CUMBERLAND,MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 16 2001	▶ Geneva B Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Amended #9, MHS, 7/17/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
MARTHA	MILLER	July 12 2001	10:18 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
THE Johns Hopkins Hospital	Baltimore City	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-34-4918	1☐ M 2☒ F	65 Yrs.			May 09, 1936	~~Lonaconing~~, MD.

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Lonaconing	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3 Watercliffe Street	21539	USA

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Give Yeer or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grada completed)		16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12		Homemaker	Home

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Roland Staup	Grace Elliott

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Robert W. Miller-Husband	3 Watercliffe Street, Lonaconing, Md . 21539

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar (Specify)	Frostburg Memorial Park	July 15, 2001	Frostburg, Maryland

21. Signeture of Funeral Service Licensee	22. Neme end Address of Fecility
▶ Jane E. McKenzie	Eichhorn-McKenzie Funeral Home P.A., Lonaconing, Md. 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the death. Do not entar tha moda of dying, such as cardiac or raspiretory arrast, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in deeth) a.	ACUTE MYELOID LEUKEMIA	1 MONTH
Due to (or es e consequence of):		
b.	ACUTE RENAL FAILURE	1 WEEK
Due to (or es e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c.	ADULT RESPIRATORY DISTRESS SYNDROME	1 WEEK
Dua to (or as a consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes cese referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	RES - 000	July 12, 2001

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

Luis Diaz Johns Hopkins 600 N. Wolfe St Baltimore, MD 21287

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
JUL 17 2001	▶ Penny P Sparks

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24188

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILMA L. McDONALD

2. Date of Death — Month: July Day: 15 Year: 2001

3. Time of Death: 10:05 a.m.

4a. Facility Name *(If not institution, give street and number)*: Moran Manor Nursing Home

4b. City, Town, or Location of Death: Westernport

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 235-30-2050

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 8, 1922

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 123 East Piedmont Street

10f. Zip Code: 26726

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laboratory Technician

16b. Kind of Business/Industry: Chemical Manufacturing

17. Father's Name *(First, Middle, Last)*: James Billmyre

18. Mother's Name *(First, Middle, Maiden Surname)*: Della Rotruck

19a. Informant's Name/Relationship *(Type, Print)*: Carol Sue Nesbit / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 133 Orchard Street Keyser, WV 26726

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Knobley Cemetery — Date: July 18 2001

20c. Location - City or Town, State: Martin, WV

21. Signature of Funeral Service Licensee: ▶ Brian L Smith

22. Name and Address of Facility: Smith Funeral Home 85 South Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma of Lung — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive pulmonary Disease; Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jesus Tan

29c. License number: D21244

29d. Date signed *(Month, Day, Year)*: 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jesus Tan, M.D. 10701 New Georges Creek Road SW #3 Frostburg, MD 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: ▶ Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-3921-041
crn
Robin Lynn Merryman

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 100901:ITEMS#23a,27 per ME G800 ss

Certificate of Death

Reg. No. 2001 24189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Robin Lynn Merryman	July	15	2001	9:17 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Easton Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-88-0830	1☐ M 2☒F	42 Yrs.					December 16, 1958	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Caroline	Ridgely	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
206 Caroline Avenue	21660	United States

11. Merital Status	12. Wes Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Raca - Amarican Indian, Black, White, atc.
1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No *Specify:*	*Specify:* Caucasian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
8		Line Worker	Education

17. Father's Nema (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumema)
John Spurgeon Morris, Sr.	Caroline Isabelle Jester

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
John S. Morris, Sr. Father	206 Caroline Avenue, Ridgely, Maryland 21660

20a. Method of Disposition	20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)	Capitol Crematory	7/17/01	Dover, Delaware

21. Signature of Funerel Service Licansee	22. Name and Address of Facility
Randolph A. Moore	Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert teilure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Deeth
Immediata Cause (Final disease or condition resulting in death)	e. SEIZURE DISORDER	
	Due to (or es a consequenca of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last	b.	
	Dua to (or as a consequenca of):	
	c.	
	Due to (or es e consaquenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth	28a. Deta of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
[signature]	O.C.M.E.	July 16, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
J. Eaton Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signeture
JUL 17 2001	[signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24190

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Earl W. Osborne, Jr.

2. Dete of Deeth — Month / Dey / Year: July 11, 2001

3. Time of Death: 8:35 PM

4a. Facility Name *(If not institution, give street end number)*: Bradford Oaks Nursing Center

4b. City, Town, or Location of Deeth: Clinton

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-09-4914

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 89 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: May 18, 1912

9. Birthplace *(Stete or Foreign Country)*: D.C.

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5204 West Mapleshade Lane

10f. Zip Code: 20772

10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Business/Industry: Exterior Decorating

17. Father's Neme *(First, Middle, Last)*: Earl W. Osborne, Sr.

18. Mother's Neme *(First, Middle, Maiden Surname)*: Pearl Osborne (Unobtainable)

19a. Informent's Neme/Reletionship *(Type, Print)*: Virginia Osborne/Spouse

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5204 West Mapleshade Lane, Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Fort Lincoln Cemetery — Dete: 07-16-2001

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funerel Service Licensee: [signature]

22. Neme and Address of Fecility: Fort Lincoln Funeral Home, 3401 Bladensburg Rd., Brentwood, MD 20722

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line.

Approximate Intervel Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: [signature]

29c. License number: D-18545

29d. Date signed *(Month, Day, Year)*: July 12, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Philip Wisotsky, M.D. 12070 Old Line Center, Waldorf, Maryland 20602

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUL 17 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24191

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John C. Orem
2. Date of Death — Month: July; Day: 14; Year: 2001
3. Time of Death: 5:00a M
4a. Facility Name *(If not institution, give street and number)*: 28055 Ridge Road
4b. City, Town, or Location of Death: Damascus
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-30-3588
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 8, 1912
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Damascus
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 28055 Ridge Road
10f. Zip Code: 20872
10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farm Laborer
16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Nathan Orem
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Annie Holsey

19a. Informant's Name/Relationship *(Type, Print)*: Nathan W. Orem/ Nephew
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 24330 Woodfield Road, Gaithersburg, Maryland 20882

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Ptece of Disposition *(Neme of cemetery, cremetory or other piece)*: Friendship U. M. Cemetery — Dete: 7/18/01
20c. Location - City or Town, State: Damascus, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth
22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 5 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es e consequence of):
b. Congestive Heart Failure — 4 years
Due to (or es a consequence of):
c. Aortic Stonosis — 8 years
Due to (or as e consequence of):
d. Hypertension — 20 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery — Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the ceuse of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Ptace of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Kenneth J. Weiss MD
29c. License number: D14097
29d. Date signed *(Month, Day, Year)*: July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth J. Weiss M. D. 26250 Ridge Road, Damascus, Maryland 20872

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 19 2001
32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24192

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cerrell Phillips
2. Date of Death Month Day Year: July 9th 2001
3. Time of Death: 5:25 PM
4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONT

Funeral Director

5. Social Security Number: 577-44-1582
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/7/34
9. Birthplace (State or Foreign Country): W. VA.

Usual Residence of Decedent

10a. State: DC
10b. County: N/A
10c. City, Town or Location: WASHINGTON
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 5079 10th St. NE
10f. Zip Code: 20017
10g. Citizen of What Country: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 YRS
College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD MANAGER
18b. Kind of Business/Industry: food

17. Father's Name (First, Middle, Last): NEWTON W. PHILLIPS
18. Mother's Name (First, Middle, Maiden Surname): MARTHA C. SIMMS

19a. Informant's Name/Relationship (Type, Print): JOHN S. SMITH
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5081 10th St. NE, DC 20017

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEM PK
Date: 7/16/01
20c. Location - City or Town, State: LANDOVER, MD

21. Signature of Funeral Service Licensee: Juan Smith
22. Name and Address of Facility: John T. Rhines Co. 3030-12th St. NE Wash DC 20017

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. Respiratory Failure
Due to (or as e consequence of): b. Pulmonary Hypertension
Due to (or as e consequence of): c. Severe COPD
Due to (or as a consequence of): d. UROSEPSIS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Approximete Interval Between Onset end Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Type I Diabetes Mellitus
Atrial Fibrillation

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown
24e. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Negussie MD
29c. License number: D45471
29d. Date signed (Month, Dey, Yeer): 7/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YEHEWIS NEGUSSIE, M.D. 7525 Greenway Center

State Registrar

31. Date filed (Month, Dey, Yeer): JUL 19 2001
32. Registrar's Signature: D. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24193

Amend #5. Per FH PGC 7-24-01 cr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
CLARENCE	PONDS		July 16, 2001	10:00 A.M.
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	4c. County of Death	
10404 Bunch Berry Lane		Upper Marlboro	Prince George's	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~224~~ 243-84-5052	1 [X] M 2 [ ] F	49 Yrs.			Mar. 5, 1952	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Upper Marlboro	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10404 Bunch Berry Lane	20772	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [ ] No If Yes, Give Yeer or Dates:	1 [ ] Yas 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)	Military Officer	Government
	1		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Sumame)
Arlie Ponds, Sr.	Helen Saunders

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Laveen M. Ponds - Wife	10404 Bunch Berry Lane, Upper Marlboro, MD 20772

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or othar piece)	Dete	20c. Location - City or Town, Stete
1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)	Lee's Crematory	7/20/2001	Clinton, MD

21. Signature of Funerel Service Licensee	22. Nama and Address of Facility
▶ John T. Stewart, III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errast, shock, or heert failure. List only one ceuse on eech line.

		Approximate Intervel Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in death)	a. Peritoneal Carcinoma	
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of ceuse of deeth?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner?	26. Place of Deeth (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medical Examiner**: On the besis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	0053235	7/18/01

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Darryl Hill, M.D. 6104 Old Branch Ave, Temple Hills MD.

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	▶

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24194

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD WILLIAM POMA

2. Date of Death Month: July Day: 19 Year: 2001

3. Time of Death: 02:00AM

4e. Facility Name *(If not institution, give street and number)*: 12004 Pierce Road

4b. City, Town, or Location of Death: Waldorf

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 213-40-9540

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV.27,1942

9. Birthplace *(State or Foreign Country)*: PA.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12004 PIERCE ROAD

10f. Zip Code: 20601

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: NAVY VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PRINCE GEORGES POLICEMAN

16b. Kind of Business/Industry: PRINCE GEORGES COUNTY GOVT.

17. Father's Name *(First, Middle, Last)*: ROBERT POMA,JR.

18. Mother's Name *(First, Middle, Maiden Surname)*: MARIE HORN

19e. Informant's Name/Relationship *(Type, Print)*: LINDA POMA - SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12004 PIERCE ROAD WALDORF,MARYLAND 20601

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: TRINITY MEMORIAL GARDENS

Date: 7-24-01

20c. Location - City or Town, State: WALDORF,MD.

21. Signature of Funeral Service Licensee: Michael O. Raymond M00479

22. Name and Address of Facility: RAYMOND FUNERAL SERVICE,P.A. LA PLATA,MARYLAND 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [XXX] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [XXX] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death [XXX]: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [XXX] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Date signed *(Month, Day, Year)*: July 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001

32. Registrar's Signature: Brenda G. Speed

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-4155-025
CJ
Unknown 01-187
Christopher G. Pruitt

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 080301:ITEMS#23a,27,28a-f per ME G798 ss

Certificate of Death

Reg. No. 2001 24195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Christopher Gene Pruitt	July	23	2001	03:01 P.M.

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stafford Road-1 Mile North of Rockrun Road	Stafford	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-76-8893	1☒ M 2☐ F	27 Yrs.					Oct. 26, 1973	Maryland

Usual Rasidance of Dacedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Havre de Grace	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
112 Wilson Street	21078	U.S.A.

11. Marital Stetus	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, alc.)	14. Race - Amaricen Indian, Black, White, etc.
1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:	1☐ Yas 2☒ No *Specify:*	*Specify:* White

15. Decedent'a Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired)	16b. Kind of Businass/Industry
Elamentary/Secondary (0-12)	Collega (1-4or 5+)		
12	0	Laborer	Construction

17. Father's Name (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Bobby Gene Pruitt	Debra Ann Harkins

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
William T. Pruitt, Sr. (Grandfather)	112 Wilson St., Havrede Grace, MD 21078

20a. Mathod of Dispositlon	20b. Place of Disposition (Name of cemetary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cramalion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	R. A. Ferris & Co., Inc.	7/26/01	West Chester, PA

21. Signeture of Funeral Sarvice Licensee	22. Name and Address of Facility
▶ Kenneth B. Cargo	Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only ona ceuse on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disaasa or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wera autopsy findings available prior to completion of cause of death?
1☒ Yas 2☐ No	1☒ Yas 2☐ No

25. Was cesa rafarred to medical examinar?	26. Placa of Death (Check only ona)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Rasidance 6☒ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day, Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☒ Could not be datarmined	found: 7-23-01	unknown M	1☐ Yas 2☒ No	unknown

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)
found in park	Stafford Rd., No. of Rockrun Rd., Harford Co., MD

29a. Cartifiar (Check only one) 1☐ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	O.C.M.E.	July 24, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
AUG 0 1 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24196

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
THOMAS WILLIAM POOLE	July 7 2001	17:34 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212 38 5427	X 1 M 2 F	69 Yrs.			1-3-1932	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Bedford	Hyndman	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
130 Sixth Avenue	15545	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Custodian	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Graham E. Poole	Ruth E. Card

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donna B. Jenkins, caregiver	P. O. Box 502, Hyndman, PA 15545

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Hillcrest Mem'l. Park 7-11-2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Harvey H. Zeigler Funeral Home, Hyndman, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A.S.C.V.D	years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	PA MD 023844-E	July 9 ,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gregory C. Donaldson, Braddock Medical Group, Seton Drive, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 10 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

3/1
MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend #29c Per Phys.PGC Jul.18.01 gc

Certificate of Death

Reg. No. 2001 24197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STERLING JEROME QUEEN
2. Date of Death (Month, Day, Year): July 11, 2001
3. Time of Death: 2:30 AM
4a. Facility Name (If not institution, give street and number): St. Thomas More Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-42-6020
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yaer): Jan. 13, 1932
9. Birthplace (State or Foraign Country): Forestville, MD

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 408 - 58th Street, N.E.
10f. Zip Code: 20019
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1952 - 1954
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Black, Whlte, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer - Andrews AFB
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): David Thomas
18. Mother's Neme (First, Middle, Meiden Surneme): Nora Viola Queen
19a. Informant's Name/Relationship (Type, Print): Goldie V. Francis/Aunt
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 9885 Greenbelt Road, Apt. 322 Lanham, Maryland 20706
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Pk. Date: 7/17/2001
20c. Location - City or Town, State: Landover, MD
21. Signature of Funeral Service Licensee: D. Gayle
22. Name and Address of Facility: Henry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Ave., N.E. Washington, DC 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximeta Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Anoxic Encephalopathy

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es a consequence of): b. Seizure

Due to (or es a consequence of): c. Cerebrovascular accident

Due to (or as a consequence of): d.

IF FEMALE: N/A
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnency: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other sfgnificant conditions** contributing to daeth but not resulting in the underlying cause given in Part I.: Recurrent pneumonia; Dementia

23e. Did tobacco usa contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings availeble prior to completion of cause of daath? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at tha tima, date end place, and due to tha causa(s) end manner stated.

29b. Signature and title of certifier: Meer Said Zonozi M.D.
29c. License number: D 22708 ~~A 32854~~
29d. Date signed (Month, Day, Yeer): 7/14/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Meer Said Zonozi M.D. 1328 Southern Ave. S.E. #307 Wash., D.C. 20032

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: D. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Elaine Marie Resnick	July 17, 2001	7:46 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
200-24-0054	1☐ M 2☒ F	69 Yrs.			Jan. 24, 1932	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel	Crofton	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1620 Earlham Avenue	21114	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Nurse	Nursing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John J. Vergot	Elizabeth A. Riegel

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
David M. Resnick husband	1620 Earlham Avenue, Crofton, Md. 21114

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lakemont Mem. Gardens 07-20-01	Davidsonville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. Metabolic acidosis	6 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	6 hours
	Due to (or as a consequence of):	
	c. Cardiac failure	12 Hours
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bilateral lung cancer

Lymphoma

Post-operative state

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], MD	20562	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barry J. Levin MD, 10215 Fernwood Rd., Bethesda, Md. 20817

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(8)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ELSIE MAE ROBINSON	July 12, 2001	10:44 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-60-2052	1☐M 2☒F	65 Yrs.			Nov. 11, 1935	S. Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.	N/A	Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3900 - 14th Street, N.W. #106	20011	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, elc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes ☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Domestic	Self

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
King H. Greene, Sr.	Wilhelmenia Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Vivian G. Jones - Daughter	11632 Stewart Lane; Silver Spring, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☒Removel from State 4☐Donetion 5☐Other (Specify)	Hilton Cemetery	7/22/01	Jordan, S. Carolina

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vendom Freeman II	Robert O. Freeman Funeral Services, Inc. 1353 H Street, N.E.; Washington, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of): Coronary Artery Disease	years
	c. Due to (or es e consequence of): Diabetes	years
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of deeth?
1☐Yes 2☒No 3☐Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD Delvecchio, MD	D44521	7/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James A. Delvecchio, MD 1500 Forest Glen Road; Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elbert L. Roberson
2. Date of Death (Month, Day, Year): July 15, 2001
3. Time of Death: 3:40 PM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 241-32-3093
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 19, 1913
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9422 Washington Blvd.
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: PVT

17. Fathar's Neme (First, Middle, Last): Augustus Roberson
18. Mother's Name (First, Middle, Maiden Sumame): Ada Doggott

19a. Informant's Neme/Reletionship (Type, Print): Neanearl Roberson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9422 Washington Blvd. Lanham, MD 20706

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cramation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Ft. Lincoln Cemetery
Date: 7/20/01
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funerel Service Licensee: ▶ K. Wil
22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
a. RENAL FAILURE — Week(s)

Due to (or es a consequence of):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — Year(s)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RESPIRATORY FAILURE / VENTILATOR Dependent

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Paul A. DeVore MD
29c. License number: D01852
29d. Date signed (Month, Day, Year): JULY 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE, MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RJD
ALISHA RICARD
01-3898-033

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alicia Rickard
2. Date of Death (Month, Day, Year): JULY 13, 2001
3. Time of Death: 2031 P.M.

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-96-1967
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 26 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 7, 1975
9. Birthplace (State or Foreign Country): Wash., DC

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1645 C St., N.E.
10f. Zip Code: 20002
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter Apprentice
16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Louis Arrington
18. Mother's Name (First, Middle, Meiden Surname): Veronica Rickard

19a. Informant's Name/Relationship (Type, Print): Veronica Arrington - Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1645 C St., N.E. Wash., DC 20002

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Harmony Memorial Park
Date: 7/19/2001
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Causa (Final disease or condition resulting in death): e. Multiple gunshot wounds
Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaese or injury that initiated events resulting In deeth) Last:
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examinar? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Found 7-13-2001
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject was shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): House
28f. Location (Street and Number or Rural Route Number, City or Town, State): 132 56th Place, S.E. Washington, D.C.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and mannar es stated. 2☒ **Medical Examiner:** On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and dua to the ceusa(s) and menner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): JULY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth Lewis Reshenberg, Jr.
2. Date of Death (Month, Day, Year): July 16, 2001
3. Time of Death: 6:00 pm
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214-42-4355
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 4, 1944
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 4900 Riverdale Road
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Kenneth Lewis Reshenberg, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Emma Ruth Reshenberg

19a. Informant's Neme/Reletionship (Type, Print): Melissa Reshenberg - Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 15702 Dorset Road, #304, Laurel, MD 20707

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Wallace Memorial Park
Date: 7/22/2001
20c. Location - City or Town, Stete: Rainelle, West Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Hepatic Encephalopathy	2 months
Due to (or es a consequence of): b.	Cirrhosis	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of): c.	Hepatitis C	years
Due to (or as e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Respiratory Failure
Ventilator Dependence

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D01852
29d. Date signed (Month, Day, Year): July 17, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STALEY WILLIAM RAMSBURG
2. Date of Death (Month, Day, Year): JULY 17, 2001
3. Time of Death: 11:00 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-30-2970A
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 18, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Walkersville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9201 Dublin Road
10f. Zip Code: 21793
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dairy Farmer
16b. Kind of Business/Industry: Self

17. Father's Name (First, Middle, Last): Harry E. Ramsburg
18. Mother's Neme (First, Middle, Maiden Surneme): Elsie M. Sponseller

19a. Informant's Name/Relationship (Type, Print): Helen Ramsburg/wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9201 Dublin Road Walkersville, MD 21793

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Resthaven Mem. Gardens
Date: July 20, 2001
20c. Location - City or Town, Stete: Frederick, MD

21. Signature of Funeral Service Licensee: Paul P. B. Hanby
22. Name end Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart feilure. List only one cause on eech line.

		Approximata Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis Syndrome	Hours
Due to (or es e consequence of): b.	Pneumonia	Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Dua to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Chronic Obstructive Pulmonary Disease; Pulmonary Hypertension

23b. Did tobacco uae contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at tha time, dete end plece, and due to the cause(s) and mannar steted.

29b. Signature and title of certifier: M Tolino MD
29c. License number: MD 51610
29d. Date signed (Month, Day, Year): 7-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1475 Taney Ave Suite 204 Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signetura: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24204

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN B. RAMSBURG
2. Date of Death Month / Day / Year: JULY 18 2001
3. Time of Death: 9:50pm
4a. Facility Name *(If not institution, give street end number)*: ROCKVILLE NURSING HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216-46-9207
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG 7 1909
9. Birthplace *(State or Foreign Country)*: WASH., DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 303 ADCLARE RD.
10f. Zip Code: 20854
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER
16b. Kind of Business/Industry: DC PUBLIC SCHOOLS

17. Father's Name *(First, Middle, Last)*: HARRY V. BRYAN
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: BELLE LANHAM

19a. Informent's Name/Relationship *(Type, Print)*: SALLY KELLEY/DAUGHTER
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 15904 GERMANTOWN RD., GERMANTOWN, MD 20874

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: SMITHSBURG CREMATORY
Date: 7/20
20c. Location - City or Town, State: SMITHSBURG, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Fecility: HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD 20838

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart faiture. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. PNEUMONIA — 1 week

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptaca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: ▶ [signature]
29c. License number: D31839
29d. Date signed *(Month, Day, Year)*: JULY 19, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER DUNFORD, MD 615 W. MONTGOMERY AVE., ROCKVILLE, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24205

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Andre Stewart

2. Data of Death: Month July; Day 11; Year 2001

3. Time of Death: 4:00PM

4e. Facility Name *(If not institution, give street and number)*: 9301 Small Drive

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-02-8762

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1962

9. Birthplace *(State or Foreign Country)*: Wash., DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9301 Small Drive

10f. Zip Code: 20735

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Best Stewart, Jr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Janice Levy

19e. Informant's Name/Relationship *(Type, Print)*: Cynthia Stewart - Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3326 M.L.King, Jr. Ave., S.E. Wash., DC 20032

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lee's Crematory

Data: 7/17/2001

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: ▶ John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. [illegible] — Approximate Interval: mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: AIDS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D19431

29d. Date signed *(Month, Day, Year)*: 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank M. Ryan MD 11701 Huntington Rd #203 Ft. Washington MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24206

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Wilhelmina Sherry
2. Date of Death — Month: July Day: 12 Year: 2001
3. Time of Death: 3:00 PM
4a. Facility Name *(If not institution, give street and number)*: 2416 Dorchester Road
4b. City, Town, or Location of Death: Upper Marlboro
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-56-8002
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 17, 1915
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2416 Dorchester Road
10f. Zip Code: 20774
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: In Home

17. Father's Name *(First, Middle, Last)*: William E. Sherry
18. Mother's Name *(First, Middle, Maiden Surname)*: Etta E. Sutton

19a. Interment's Name/Relationship *(Type, Print)*: Kathleen Huckeba / Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2416 Dorchester Road Upper Marlboro, Maryland 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Wash. Nat'l. Cemetery
Date: 07/16/2001
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. OVARIAN CANCER — 2 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tony J. Kalas
29c. License number: D20352
29d. Date signed *(Month, Day, Year)*: 7/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harry Hatten 8726 Woodyard Rd Clinton MD

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001
32. Registrar's Signature: Jeanne B. Spates

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Michael		Smith	07 / 09 / 2001	2131 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical Center	Baltimore, Maryland	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
557-80-0842	1☑M 2☐F	45 Yrs.			01, 27, 1956	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	n/a	Baltimore	XX 1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6002 Amberwood Road #B4	21206-6274	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced	1☐Yes 2☒No XX If Yes, Give Year or Dates:	1☐Yes 2☐No XX Specify:	Specify Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Electrical Services	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Beulah Warnes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Wilkerson Wife	4969 8th Street NE, Washington, D.C. 20017

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill Cemetery	07-18-01	Suitland, MD

21. Signature of Funeral Service Licensee		22. Name end Address of Facility
▶	MD01257	Bianchi Funeral Service 814 Upshur Street NW, Washington, DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Sepsis	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

Hepatic Insufficiency

23e. Did tobecco use contribute to the ceuse of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Douglas D. Mayo MD	P 13393	07, 09, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas D. Mayo, MD University of Maryland Medical Center

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Veda Samuels	07 / 09 / 2001	9:41p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☐ M 2☒ F	57 Yrs.			07-27-1944	Jamaica

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Clinton	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5906 Butterfield Dr.	20735	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Sales	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Melbert Williams	Lucille Johnson

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacqueline Benaine/Daughter	5906 Butterfield Dr. Clinton, MD 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Logwood	7/21/2001	Black River, Jamaica

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Md 20785

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Heart Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown	23d. Dete of delivery Month / Dey / Year

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Ketoacidosis, Hemorrhagic colitis

Sepsis syndrome, Disseminated intravascular coagulation

Anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Wes case referred to medical exeminer?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted.

2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Yeer)
▶ [signature] MD	D 39501	July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugh M. Holder, MD 101 Stone Gate Dr. Silver Spring, MD 20905

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24209

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Deborah D. Scott
2. Date of Death (Month, Day, Year): June 30, 2001
3. Time of Death: 1:58 AM
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-74-2328
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 15, 1953
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: D.C.
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 118 48th Place, N.E.
10f. Zip Code: 20019
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elamantary/Secondary (0-12): 10th grade
College (1-4or 5+):
16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: F.B.I. (Federal Government)

17. Father's Name *(First, Middle, Last)*: James Scott
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Jane Scott

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Charles N. Scott (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 118 48th Place, N.E. Washington, D.C. 20019

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: National Harmony Mem. Park
Date: 7/7/01
20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensaa: Janet C. Anderson
22. Name and Address of Facility: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in daath) a.	Sepsis Methacillin Resistant Staph	2 weeks
Due to (or as a consequence of): b.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last — Due to (or as a consequenca of): c.		
Dua to (or as a consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirvonic Encephalopathy
Diabetes Mellitus type II
Multiple Decubiti

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to complation ot causa of death? 1☐ Yes 2☒ No

25. Was casa raferrad to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, straet, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)*: 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and placa, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifiar: Paul A. DeVore MD
29c. Licensa number: D01852
29d. Date signed *(Month, Day, Year)*: JUNE 30 2001

30. Nama and addrass of person who complated cause of daath (Item 23a) (Type, Print): PAUL A. DeVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 19 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24210

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Roger Simmons
2. Date of Death (Month, Dey, Yeer): July 18, 2001
3. Time of Death: 8:05am M
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 239-60-2758
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Aug. 16, 1938
9. Birthplace (State or Foreign Country): Halifax, N.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2003 Olegthorpe Pl. #201
10f. Zip Code: 20782
10g. Citizen of What Country?: United States

11. Maritat Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Security Officer
16b. Kind of Business/Industry: Private Business

17. Father's Name (First, Middle, Last): William Simmons
18. Mother's Neme (First, Middle, Maiden Surneme): Isabell Britt

19a. Informant's Name/Relationship (Type, Print): Doretha L. Simmons
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3604 Scruggs Pl. Springdale, Md. 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Glenwood Cemetery
Dete: July 21,2001
20c. Location - City or Town, Stete: Washington, D.C.

21. Signature of Funeral Service Licensee: Kathleen Savoy MO1085
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner — Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finat disease or condition resulting in death): a. Esophageal Cancer

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin D. Weltz
29c. License number: D 23743
29d. Date signed (Month, Dey, Yeer): July 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin D. Weltz 7525 Greeway Ct. Dr. Greenbelt, Md. 20770

State Registrar

31. Date filed (Month, Dey, Yeer): JUL 20 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Andrew R. Sawyer	July 19, 2001	4:30A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6530 Suitland Rd.	Morningside	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
294-05-1915	1☒M 2☐F	80 Yrs.			Nov. 5, 1920	Maine

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Morningside	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6530 Suitland Road	20746	U.S A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1940-1945	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Engineer	Electrical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clarence Sawyer	Mabel Tan

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lorraine Sawyer (Wife)	6530 Suitland Road Morningside, Maryland 20746

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place) Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	July 24,2001 Maryland State Veterans Cemetery	Cheltenham, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dawn L. Grant	Lee Funeral Home, Inc. 20735 6633 Old Alexandria Ferry Road Clinton, MD

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Cardiac arrythmia	Unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	Due to (or as a consequenca of): b. Coronary Artery disease	5yr
	Due to (or as e consequence of): c. Aneurysm of aorta	5yr
	Due to (or as a consequence of): d. Chronic Lung disease	5yr

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probebly 4☐Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ MD Attending	D-24535	07-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa, M.D. 7700 Old Branch Ave. C101, Clinton, Md. 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tyler Scott SHAFFER
2. Date of Death: Month 7 Day 14 Year 2001
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): Univ. of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours 23 Min. 30
8. Date of Birth (Month, Day, Year): 7-13-01
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 641 B Hughes Shop Road
10f. Zip Code: 21158
10g. Citizen of What Country? USA

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Charles A.L. Shaffer
18. Mother's Name (First, Middle, Maiden Surname): Angela D. Moffitt

19a. Informant's Name/Relationship (Type, Print): Charles A.L. Shaffer/father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 641 B Hughes Shop Road Westminster, MD 21158

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Pk
Date: 7/18/2001
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: John K. Adg
22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finet disease or condition resulting in death)
a. Respiratory Failure Secondary to Pulmonary Insufficiency 6hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Bladder Outlet Obstruction
Due to (or as a consequence of):
c. Dysplastic Kidneys
Due to (or as a consequence of):
d. Clinical Sepsis

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 X Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Michael A. Thompson MD
29c. License number: D48333
29d. Date signed (Month, Day, Year): 7-14-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Thompson MD, 22 South Greene St., Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

WJL 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Jane Smith
2. Date of Death (Month, Day, Year): July 15, 2001
3. Time of Death: 9:07 a.m.
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 285-22-2559
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 24, 1924
9. Birthplace (State or Foreign Country): Portsmouth, Ohio

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4502 Brightwater Ct. Apt. T1
10f. Zip Code: 21117
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): +4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): 6th grade teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Jessie B. Brooks
18. Mother's Name (First, Middle, Maiden Surname): Estellea M. Hans

19a. Informant's Name/Relationship (Type, Print): Raymond F. Smith - husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4502 Brightwater Ct. Apt. T1 Owings Mills, Md. 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Quantico Nat'l Cem. Date: July 19, 2001
20c. Location - City or Town, State: Triangle, Virginia

21. Signature of Funeral Service Licensee: Justin R. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UTERINE CANCER	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D43725
29d. Date signed (Month, Day, Year): 7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001
32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JULY 15, 2001 9:07 a.m.
Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,
BETTY JANE SMITH

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR
6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24214

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert SHEARER
2. Date of Death: Month July Day 13 Year 2001
3. Time of Death: 7:30PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 215-58-3338
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 6, 1950
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 983 Chestnut Manor Ct.
10f. Zip Code: 21226
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1969-1973 Navy
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Collections Manager
16b. Kind of Business/Industry: Key Bank & Trust
17. Father's Name (First, Middle, Last): Edgar Francis Shearer
18. Mother's Name (First, Middle, Maiden Surname): Mollie Maybelle Patten
19a. Informant's Name/Relationship (Type, Print): Teresa Ann Shearer - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 983 Chestnut Manor Ct. Baltimore, Md. 21226
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Md. Veterans Cemetery
Date: July 17, 2001
20c. Location - City or Town, State: Owings Mills, Md.
21. Signature of Funeral Service Licensee: Dustin R. Dunbar
22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiogenic Shock
Due to (or as a consequence of):
b. Myocardial infarction
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary artery disease.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Segueira
29c. License number: D0024726
29d. Date signed (Month, Day, Year): July 14 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alejandro Segueira M.D. Sinai Hospital 2401 West Belvedere Ave. Baltimore, Md. 21215

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 10+3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24215

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beulah Leona Spellman

2. Date of Death Month: JULY Day: 15 Year: 2001

3. Time of Death: 11:05 AM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-07-1871

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul 7, 1902

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1103 West 42nd Street

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Knothe Brothers

17. Father's Name *(First, Middle, Last)*: La Mar Kurtz Cullison

18. Mother's Name *(First, Middle, Meiden Surname)*: Esta Elvira Wilhelm

19a. Informant's Name/Relationship *(Type, Print)*: Inabelle Mahan, niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1000 E. Joppa Rd apt 504, Baltimore, Md 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Grace UM Cemetery

Date: 7/18/2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven K Eline MD0723

22. Name and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cardiopulmonary Arrest — 12 hours

Due to (or as e consequence of):

b. due to hyperkalemia — 12 hours

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

Due to (or as a consequence of):

c. metabolic acidosis — 12 hours

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnent at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASTHMA, HYPOTHYROIDISM

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jane Wilson, MD

29c. License number: AT 2438946

29d. Date signed *(Month, Day, Year)*: 7/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jane Wilson, Union Memorial Hospital, 201 E. University Parkway, Baltimore, MD 21218

WJZ 6

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
ANNIE MAE STANTON	July 11 2001	10:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2400 BARCLAY ST	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-20-9919	1 ☐ M 2 ☑ F	78 Yrs.			JUNE 17, 1923	VIRG.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		BALTIMORE	1 ☑ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2400 BARCLAY ST.	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 TH		CARE TAKER	PRIVATE FAMILY CHILDREN

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANDREW HARRIS	KATE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JANE DOWNS (DAU)	819 BENNINGHAUS RD. BALT. MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MT. CALVARY CEM.	JULY 16, 2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gary L. Rollins	Gary L. Rollins Funeral Home 110 WEST SOUTH ST FRED. MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial fibrillation.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM-type II
HTN.

23e. Did tobacco use contribute to the ceuse of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] Internist	D48105	07/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ujoala Deson, 3301, Belair Rd, Balt. MD-21213

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24217

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MABEL IRENE SNEAD
2. Date of Death Month Day Year: JULY 14, 2001
3. Time of Death: 8:55AM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-16-0384
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 1, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7054 Basswood Road
10f. Zip Code: 21703
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Elevator Operator
16b. Kind of Business/Industry: County Government

17. Father's Name *(First, Middle, Last)*: Charles William McDonald
18. Mother's Name *(First, Middle, Maidan Sumame)*: Minne Bambers

19a. Informant's Name/Ralationship *(Type, Print)*: Paulette Riley/ Daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5664 Crabapple Drive, Frederick, Maryland 21703

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or other place)*: Bethesda Methodist Cemetery — Data: 7/17/01
20c. Location - City or Town, State: Damascus, Maryland

21. Signature of Funeral Sarvice Licensee: Todd D Wigner
22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failura. List only one cause on aach lina. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PRIMARY BILIARY CIRRHOSIS — 5 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese rafarred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to tha ceusa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Mary P. Howell MD
29c. License number: 046075
29d. Date signed *(Month, Day, Year)*: 7/14/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Mary P. Howell, M.D. 170 Thomas Johnson Drive Frederick, Maryland.

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24218

FRED SULLIVAN 218-16-3408

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): FREDERICK ALTON SULLIVAN, SR.

2. Date of Death (Month, Dey, Year): JULY 07 2001

3. Time of Death: 15:15

4e. Facility Neme (If not institution, give street end number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

5. Social Security Number: 218-16-3408

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthdey): 78 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): SEPT. 10,1922

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. Stete: MD

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 14200 PINTO ROAD, S.W.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11 — College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ELECTRICIAN

16b. Kind of Business/Industry: ELECTRICAL

17. Fether's Neme (First, Middle, Last): CHARLES CLARY SULLIVAN

18. Mother's Name (First, Middle, Maiden Surname): VIRGINIA MAE WRIGHT

19e. Informent's Name/Reletionship (Type, Print): VELMA ROSE SULLIVAN / WIFE

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 14200 PINTO ROAD, SW, CUMBERLAND, MD 21502

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other piece): HILLCREST BURIAL PARK

Dete: 07/10/2001

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Hendy D. Upchurch

22. Neme end Address of Fecility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death): e. Pneumonia — 5 days

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b. Due to (or es e consequenca of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier:

29c. License number: D0033280

29d. Date signed (Month, Day, Year): JULY 8, 2001

30. Neme snd eddress of person who completed cause ot deeth (Item 23a) (Type, Print): GUPTA, SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

State Registrar

31. Dete filed (Month, Day, Year): JUL 12 2001

32. Registrer's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24219

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Dorothy Dodd Stephen
2. Date of Death Month Day Yaar: July 14, 2001
3. Tima of Death: 12:05 p.m.
4a. Facility Nema (If not institution, give street end number): Moran Manor Health Care
4b. City, Town, or Location of Daath: Westernport
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 232-62-7275
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 79 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Sept.5,1921
9. Birthplaca (State or Foreign Country): West Virginia

Usual Rasidance of Dacedent

10a. Stete: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 215 D Street
10f. Zip Code: 26726
10g. Citizan of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Spacify only highast grade complatad): Elamentary/Secondary (0-12): Collega (1-4or 5+): 4+
16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Elementary Music Teacher
16b. Kind of Business/Industry: Public School

17. Fathar's Nama (First, Middle, Last): Fred Hamill
18. Mother's Nema (First, Middle, Maiden Surname): Sarah Edith Dodd

19a. Informant's Name/Relationship (Type, Print): Dorothy Lynn Taylor (Daughter)
19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Coda): 939 Braddock Road, Cumberland, Maryland 21502

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)
20b. Placa of Disposition (Nama of cemetery, crematory or othar placa): Queens Point Cemetery
Data: 7/17/01
20c. Location - City or Town, Stata: Keyser, West Virginia

21. Signature of Funaral Service Licensee: ▶ Harold Dean Hofsinger
22. Nama and Addrass of Facility: Markwood Funeral Home 111 S. Mineral St., Keyser, West Virginia 26726

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only ona causa on aach tina.

Approximeta Interval Between Onset and Death

Immadiata Causa (Final disaese or condition resulting in daath)
a. Recurrent Sepsis — 1 month
Due to (or es e consequenca of):
b. Recurrent Urinary Tract Infection — 1 week
Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated avants resulting in death) Last
c.
Dua to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.
Parkinson disease · Hypothyroidism
Chronic Anemia · multiple decubiti

23b. Did tobacco use contributa to the causes of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? NO 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to compltion of causa of daath? 1☐ Yas 2☐ No

25. Was casa referred to medical exeminer? 1☐ Yas 2☒ No
26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Ptece of Injury - At home, farm, street, fectory, office building, atc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinton, death occurred at tha tima, deta and placa, and due to the cause(s) and manner steted.

29b. Signatura and titla of certifier: ▶ [signature]
29c. Licanse number: D21244
29d. Date signed (Month, Day, Year): July 16, 2001

30. Name and eddrass of person who completed causa of daath (Item 23a) (Type, Print): Dr. Jesus H. Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532

State Registrar

31. Data filed (Month, Day, Year): JUL 16 2001
32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Per C Rite MU 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24220

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IDA MYRTLE SWAUGER
2. Date of Death — Month: JULY Day: 13 Year: 2001
3. Time of Death: 7:15 a.m.
4a. Facility Name *(If not institution, give street and number)*: 13004 ROSEMARY LANE, NW
4b. City, Town, or Location of Death: MT. SAVAGE
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215 20 5550
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN 4 1925
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: MT. SAVAGE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13004 ROSEMARY LANE, NW
10f. Zip Code: 21545
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SPINNING
16b. Kind of Business/Industry: CELANESE

17. Father's Name *(First, Middle, Last)*: CHARLES HARBEL
18. Mother's Name *(First, Middle, Maiden Surname)*: IDA WALBOTT

19a. Informant's Name/Relationship *(Type, Print)*: RANDY SWAUGER / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13004 ROSEMARY LANE, NW, MT. SAVAGE, MD 21545

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: FROSTBURG MEMORIAL PARK — Date: 7/16/01
20c. Location - City or Town, State: FROSTBURG, MD

21. Signature of Funeral Service Licensee: ▶ Alan M Sowers
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CARCINOMA of the Pancreas	3 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined
28a. Pleca of Injury - At homa, farm, straat, factory, offica building, etc. *(Specify)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Chaney M.D.
29c. License number: D25638
29d. Date signed *(Month, Day, Year)*: July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA CHANEY M.D 10701 New Georges Creek S.W Suite 3 Frostburg Maryland 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001
32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

MS-4 MV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Theodore R. Taylor	7 / 16 / 01	7:08A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-14-6917	1 [X] M 2 [ ] F	96 Yrs.			12-1-04	Wash., D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Prince Georges	Capital Heights	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
400 Milwolf Drive	20743	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Brick Mason	Masonary
	2		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John William	Geertrude Blakey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Gladys Taylor (wife)	400 Milwolf Dr., Capital Heights MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)	Harmony Memorial	7/19/01	Landover, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Lisa A. Berry M01178	B.K. Henry Funeral Chapel 420 H St. N.E. Wash., DC. 20002

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cardiac arrest — minutes

Due to (or as a consequence of):
b. Acute Myocardial infarction — minutes

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnency 1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnency 4 [ ] Pregnant et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown	23d. Dete of delivery Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No	26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] Er/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner es stated.
2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Sam Tellawi	D34274	7.17.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sam Tellawi Southern Maryland Hospital Clinton, Md.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Thomas

2. Date of Death — Month: July Day: 12 Year: 2001

3. Time of Death: 1855

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 098-24-7089

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/16/1926

9. Birthplace (State or Foreign Country): Virgin Island

Usual Residence of Decedent

10a. State: MD

10b. County: PG

10c. City, Town or Location: Landover

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2111 Columbia Ave.

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 7/4/45 - 12/1/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 4 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): clerk

16b. Kind of Business/Industry: U.S. Post Office

17. Father's Name (First, Middle, Last): Lionel G. Lang

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Lionel G. Thomas/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4300 23rd Pl. Temple Hills.Md. 20748

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): MD. VET. CEMETERY

Date: 7/23/01

20c. Location - City or Town, State: Cheltenham,Md.

21. Signature of Funeral Service Licensee: Henry Hodges

22. Name and Address of Facility: HODGES AND EDWARDS 3910 Silver Hill Rd. Suitland,Md.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or hear failure. List only one cause on eech lina.

Approximate Intarval Between Onset end Death

Immediate Ceusa (Final diseesa or condition resulting in daath)

e. Atherosclerotic Cardiovascular Heart Disease

Due to (or as e consequence of):

Sequantially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester MD

29c. License number: MD055927

29d. Date signed (Month, Day, Year): July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

(4) IVA RJ

Amended #23b, nls 7/13/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES EDWARD TRUKA

2. Date of Death Month: July Day: 12 Year: 2001

3. Time of Death: 2:50 P M

4e. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 279-07-3652

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 9 1917

9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 1814 BEDFORD STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): CELANESE CORP. OF AMERICA

16b. Kind of Business/Industry: ENGINEER

17. Father's Name (First, Middle, Last): EDWARD WENTZ TRUKA

18. Mother's Name (First, Middle, Meiden Sumeme): MARTHA WITTER

19e. Informant's Name/Relationship (Type, Print): PAUL TRUKA BROTHER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1822 NORTH UNION STREET WILMINGTON, DEL. 19806

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): OAKWOOD CEMETERY Dete: JULY 17 2001

20c. Location - City or Town, State: BUCYRUS, OHIO

21. Signature of Funerel Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. congestive hart failure — 3 weeks

Due to (or as a consequence of): b. myocardial infarction — 3 weeks

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant et time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: abdominal aortic aneurysm; pneumonia

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Roy Chisholm MD

29c. License number: D34362

29d. Date signed (Month, Dey, Year): JULY 12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roy Chisholm MD. 924 Seton Drive Cumberland MD 21502

State Registrar

31. Dated (Month, Day, Year): JUL 13 2001

32. Registrar's Signature: George B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 Yrs

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josephine Gonzalez Turnbaugh
2. Date of Death (Month, Day, Year): July 16, 2001
3. Time of Death: 1:05 p. M
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-26-2832
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 2, 1922
9. Birthplace (State or Foreign Country): Cayey, Puerto Rico

Usual Residence of Decedent

10a. State: Md.
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4044 Old Washington Road
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Puerto Rican
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Psychiatric Aid
18b. Kind of Business/Industry: Mental Health

17. Father's Name (First, Middle, Last): Raphael Gonzalez
18. Mother's Name (First, Middle, Meiden Surneme): Ana Carrasquillo

19a. Informant's Name/Reletionship (Type, Print): Mary Ann Hudson - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 921 Klees Mill Road Westminster, Md. 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Dulaney Valley Mem. Gardens
Dete: July 18, 2001
20c. Location - City or Town, Stete: Timonium, Md.

21. Signature of Funeral Service Licensee: Justin R. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cirrhosis, Cryptogenic — 10 years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or es e consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hepato Renal Syndrome

23e. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2☐ Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: T. Galvin
29c. License number: D31660
29d. Dete signed (Month, Dey, Yeer): 07/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS GALVIN III 291 STONEL AVE WESTMINSTER MD 21157

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

WJR 12

ADH
RONALD VOPICKA
01-3853-021

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24225

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Vandersee Vopicka
2. Date of Death: Month JULY Dey 11, Year 2001
3. Time of Death: 1548 PM
4a. Facility Name (If not institution, give street and number): MARKER ROAD & BIDLE ROAD
4b. City, Town, or Location of Death: MIDDLETOWN
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 155-30-3580
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Nov. 4, 1938
9. Birthplece (State or Foreign Country): New Jersey

Usuel Residence of Decedent

10a. Stete: MD.
10b. County: Frederick
10c. City, Town or Location: Middletown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 7390 Freestate Dr.
10f. Zip Code: 21769
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: 1961-1965
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): electronics engineer
16b. Kind of Business/Industry: computer co.
17. Fether's Name (First, Middle, Last): Edward Vopicka
18. Mother's Name (First, Middle, Maiden Surneme): Carolina Laura Vandersee
19a. Informent's Name/Relationship (Type, Print): Linda D. Vopicka (Wife)
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 7390 Freestate Dr., Middletown, MD. 21769
20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other place): Smithsburg Crematory
Dete: 7/14
20c. Location - City or Town, Stete: Smithsburg, MD.
21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Facility: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line. (Approximete Interval Between Onset and Death)

Immediate Cause (Final diseese or condition resulting in deeth): e. Head and Neck Injuries
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [X] Yes 2 [ ] No
25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Plece of Deeth (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE
27. Manner of Death: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer): 7/11/01
28b. Time of Injury: 3:40 found M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Bicyclist impacted rocks
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): STREET
28f. Location (Street end Number or Rurel Route Number, City or Town, State): MARKER and BIDLE ROAD Middletown, MD
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [X] Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: [signature]
29c. License number: OCME
29d. Date signed (Month, Dey, Year): JULY 12, 2001
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): John M. Tilny, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JUL 16 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24226

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DANIEL ROLAND VIGUE

2. Date of Death: Month July, Day 16, Year 2001

3. Time of Death: 8:42 A.M.

4e. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 140-38-9982

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 18, 1944

9. Birthplace *(State or Foreign Country)*: Maine

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 860 W. Watersville Road

10f. Zip Code: 21771

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Director of Facilities

16b. Kind of Business/Industry: Human Genome Sciences

17. Father's Name *(First, Middle, Last)*: Philip J. Vigue, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Juliet Pomerlean

19a. Informant's Name/Relationship *(Type, Print)*: Mary M. Vigue/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 860 W. Watersville Road Mt. Airy, MD 21771

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pine Grove Cemetery

Date: July 20, 2001

20c. Location - City or Town, State: Mt. Airy, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon cancer — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D43083

29d. Date signed *(Month, Day, Year)*: July 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE A. SOTOS, MD 9707 Medical Center Drive #300 Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
William	Daniel	VOLK	July	12	2001	12:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
151-52-3281	1 [X] M 2 [ ] F	44 Yrs.			June 2, 1957	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Ridgeley	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Rt 2 Box 120	26753	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	Transportation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William H. Volk	Joan Garcia

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia M. Volk/Wife	Rt 2 Box 120 Ridgeley, WV 26753

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Cumberland Crematory	7/13/2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
S. Mark Simp	Upchurch Funeral Home, P.A. 202 Greene St. Cumb., MD 21502

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NON SMALL CELL LUNG Cancer Stage 4 — Approximate Interval: Unknown

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [/] Unknown	1 [ ] Yes 2 [/] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [/] No	Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D54756	July 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

DR ROBERT RAPP JR, 912 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 13 2001	Bernice D Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

MS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24228

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillian B. White-France

2. Date of Death Month / Day / Year: July 12 2001

3. Time of Death: 3:45 P.M.

4a. Facility Name *(If not institution, give street and number)*: 576 Stocketts Run Road

4b. City, Town, or Location of Death: Davidsonville

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 100-24-0391

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 11, 1920

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedant

10a. State: New York

10b. County: Queens

10c. City, Town or Location: Hollis

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 102-29 183rd Place

10f. Zip Code: 11423

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grada complated)*: Elemantary/Secondary (0-12): 12 | Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Registered Nurse

16b. Kind of Businass/Industry: Hospital/ Health Clinics

17. Fathar's Nama *(First, Middla, Last)*: Walter A. Browne

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Vivian Whitehead

19a. Informant's Name/Relationship *(Type, Print)*: Jacqueline W. Sales-Davis Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 576 Stocketts Run Rd. Davidsonville MD 21035

20a. Mathod of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, crematory or other place)*: The Huntt Crematory

Data: July 13, 2001

20c. Location - City or Town, Stata: Waldorf MD

21. Signature of Funeral Service Licensee: Robert L Boyle

22. Nama and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or raspiratory errast, shock, or heert feilure. List only ona causa on aach lina.

Approximete Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Cardiopulmonary arrest

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last

b. Adenocarcinoma of unknown primary 3 months

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☒ Other *(Specify)* Daughters Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar stated.

29b. Signatura and title of cartifier: Mary D Leahowicz MD

29c. License number: D0056692

29d. Data signed *(Month, Day, Year)*: July 13, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): 401 North Broadway Baltimore Maryland 21231

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 16 2001

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMND ITM#10E&17 PR. F.H. G799 9-14-01 JAB

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar — Amended # 20b & c

Certificate of Death

Reg. No. 2001 24229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Lucy Whitney		July 11, 2001	7:55 P M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Holy Cross Hospital	Silver Spring		Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
158-14-1529	1☐M 2☒F	88 Yrs.			Aug. 2, 1912	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	District Heights	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6624 ~~Kippling~~ KIPLING Parkway	20747	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes ☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Seamstress/ Electronics	Government

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Alvin ~~Truitt~~ TRUATT	Lottie Williams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charlotte Brown/ Niece	6624 ~~Kippling~~ Kipling Pkwy. District Heights, MD 20747

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	~~Ft.~~ Lincoln	7/19/01	Suitland, Md ~~Brentwood, MD~~

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith A. Savage M1085	Alexander S. Pope Funeral Homes 5538 Marlboro Pike/ Foresville, MD 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 1 week

Immediate Cause (Final disease or condition resulting in death): Small bowel obstuction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es steted.
2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Patel MD	6567206	7/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Plyush Patel, MD Holy Cross Hospital 1500 Forest Glen Rd. Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24230

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillian L. Wright
2. Date of Death Month / Dey / Year: July 9, 2001
3. Time of Death: 2:10AM
4a. Facility Name *(If not Institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-50-0627
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 63 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Sept 24, 1937
9. Birthplece *(State or Foreign Country)*: Washington DC

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Prince Georges
10c. City, Town or Location: Cheltenham
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11177 Crain Highway
10f. Zip Code: 20623
10g. Citizen of What Country?: U.S.A.

11. Merifel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietary Aide
16b. Kind of Business/Industry: Private

17. Father's Neme *(First, Middle, Last)*: Wallace Cook
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Fannie P. Staples

19a. Informant's Name/Raletionship *(Type, Print)*: Michael E. Folks - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3723 Cottage Terr Cottage City MD 20722

20a. Method of Disposition: 1☐ Buriel 2☒ Cramation 3☐ Ramovel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Ft. Lincoln Crematory
Dete: 7-14-01
20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signature of Funerel Service Licensee: ▶ [signature]
22. Name end Address of Feclility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd Brentwood MD 20722

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on aech line. — Approximate Interval Between Onset end Deeth

Immediate Causa (Final diseese or condition resulting in deeth)
a. Septic Shock
Dua to (or as a consequance of):
b. Osteomyelitis
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last
c. Acute Respiratory Distress Syndrome
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Pert I.: Chronic Obstruction Pulmonary Disease; Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Miranda
29c. License number: D4327K
29d. Dete signed *(Month, Day, Year)*: July 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Imelda Miranda 9554 Crain Highway Upper Marlboro MD 20772

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 17 2001
32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pearlie R. Williams
2. Date of Death (Month, Day, Year): July 15, 2001
3. Time of Death: 9:45 am M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578 32 1652
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/5/15
9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 127 Varnum St. N.W.
10f. Zip Code: 20011
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. | College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Govt.

17. Father's Name (First, Middle, Last): Theodore Mitchell
18. Mother's Name (First, Middle, Meiden Surname): Julia Henderson

19a. Informant's Name/Relationship (Type, Print): Louis Williams / Husband
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 127 Varnum St. N.W. Wash DC 20011

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Ft. Lincoln Cem. | Dete: 7-20-01
20c. Location - City or Town, State: Brentwood MD

21. Signature of Funeral Service Licensee: [signature] CC00273
22. Name and Address of Facility: John T. Rhines Co. 3030-12th St. NE Wash DC 20017

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiogenic shock — Minutes

Due to (or as e consequence of):
b. Congestive Heart Failure — Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Strep viridans Endocarditis — 4-6 weeks

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Dete of delivery: Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Aortic Stenosis, Arterial Hypertension, Asthma, Anemia secondary to hemolysis.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury al Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D08188
29d. Date signed (Month, Dey, Yeer): 07-16-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hugo G. Graziani 717 Pershing Drive Silver Spring MD 20910

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24232

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAULINE T. WILLIAMS

2. Data of Daath — Month: July Day: 16 Yaar: 2001

3. Time of Death: 1:31AM

4a Facility Nama *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Daath: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Sacurity Number: 579 22 0370

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: 3/13/17

9. Birthplaca *(Stata or Foraign Country)*: Virginia

Usual Residanca of Decadant

10a. Stata: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1510 D Street, S.E.

10f. Zip Coda: 20003

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: Black

15. Decadant's Education *(Specify only highest grada complatad)* — Elamantary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: Minister

16b. Kind of Businass/Industry: PVT.

17. Fathar's Nama *(First, Middla, Last)*: Robert Samuel Taylor

18. Mother's Name *(First, Middla, Maidan Surnama)*: Myra Claiborne

19a. Informant's Name/Relationship *(Type, Print)*: Jean E.W. Milam, Daugther

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7316 Lynnhurst Street, Chevy Chase, Md. 20815

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Chesapeake Crematory

Data: 7/23/01

20c. Location - City or Town, Stata: Beltsville, Md.

21. Signature of Funaral Sarvica Licansaa: Ruth C. Hall

22. Name and Address of Facility: HALL BROTHERS FUNERAL HOME 20001, 621 Florida Avenue, N.W., Wash., D.C.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one causa on each line.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Hepatic Failure — Days

Dua to (or as a consaquanca of):

b. Hepatic Encephalopathy — Days

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiatad avants resulting in daath) Last

Dua to (or as a consaquanca of):

c.

Due to (or as a consaquanca of):

d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to tha cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformad? 1☒ Yas 2☐ No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☒ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Spacify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signature and title of certifier: M.D.

29c. Licansa number: D0050987

29d. Data signad *(Month, Day, Yaar)*: July 18, 2001

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Ahmed Nawaz, M.D., 1299 Lamberton Street, Silver Spring, Md., 20902

State Registrar

31. Data filad *(Month, Day, Yaar)*: JUL 19 2001

32. Registrar's Signatura: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Layton Weakley
2. Data of Death (Month, Day, Year): July 18, 2001
3. Time of Death: 4:10 AM
4a. Facility Name (If not institution, give street and number): Prince George's Community Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 229-01-9990
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept. 16, 1916
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Rockingham
10c. City, Town or Location: Harrisonburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1964 Gravels Road
10f. Zip Code: 22802
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Freight
16b. Kind of Business/Industry: R.E.A. Express Co.

17. Father's Name (First, Middle, Last): Solomon Weakley
18. Mother's Name (First, Middle, Maiden Surname): Lessie Brown

19a. Informant's Name/Relationship (Type, Print): Mary Garner-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1964 Gravels Rd., Harrisonburg, VA 22802

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Elk Run Cemetery
Date: July 21, 2001
20c. Location - City or Town, State: Elkton, VA

21. Signature of Funeral Service Licensee: Dennis Pettorini
22. Name and Address of Facility: Kyger & Trobaugh Funeral Home, Harrisonburg, Virginia 22801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis / Bacteremia
Due to (or as a consequence of):
b. Candidemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Multi Organ Failure
Due to (or as a consequence of):
d. Disseminated Intravascular Coagulopathy

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease / Arrythmic
Coronary Valvular Disease
Diabetes Mellitus / Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0054794
29d. Date signed (Month, Day, Year): 07/18/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Dereje Haile, M.D. 3001 Hospital Dr., Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Michael Anthony Williams	July 12th, 2001	1820 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-92-9128	1[X] M 2[ ] F	38 Yrs.			02-27-63	Washington, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Suitland	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4729 John Street	20746	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: 1981-1985	1[ ] Yes 2[X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	(±) 1	COURIER	MAIL DELIVERY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jessie L. Lee	Sannie L. Williams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sannie L. Alston / Mother	1317 Christopher Lane Fort Washington, Maryland 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Resurection Cemetery	07-19-01	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Derek E. Sloan	Sterling Funeral Service 20019 1601 Kenilworth Avenue, N.E. Washington, D.C.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bilateral Pneumonia — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):
b. Human Immunodeficiency Syndrome — unknown

Due to (or as a consequence of):
c.

Due to (or as a consequenca of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown

23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the ceuse of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[✓] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was cese referred to medical exeminer? 1[ ] Yes 2[✓] No

26. Place of Death (Check only one)
Hospital: 1[✓] Inpatient 2[ ] ER/Outpatient 3[ ] DOA
Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death 1[✓] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1[ ] Yes 2[ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1[✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2[ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
	50454	July 13, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
9801 Georgia Avenue Suite 3-35 Silver Spring Maryland

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
JUL 20 2001	G. Sparks

Baltimore, Maryland 21215-0036

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(16)

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24235

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
HARRY IGNATIUS WOLFE, JR.	JULY 15 2001	11:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
COLLEGE VIEW CENTER	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-16-0366	1☑M 2☐F	81 Yrs.			MAY 16, 1920	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	FREDERICK	FREDERICK	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5935 BARTONSVILLE Rd.	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☑Yes 2☐No If Yes, Give Year or Dates: 1946	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4TH			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HARRY I. WOLFE, SR.	CAROLINE SPENCER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GLADYS WOLFE (WIFE)	5935 BARTONSVILLE RD. FRED. MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	RESTHAVEN MEM. GAR.	JULY 20, 2001	FRED. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gary L. Rollins	GARY L. ROLLINS FUNERAL HOME 910 WEST SOUTH ST FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ADENOCARCINOMA OF COLON	15 YRS
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or es e consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Day Year

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residenca 6☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ MD	D21936	7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. DONELSON MD 170 THOMAS JOHNSON DR. W.S., SUITE 100, FREDERICK, MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ Brenda D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
HELEN		WILES	JULY 17 2001	2345 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (If yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-18-2332	1☐M 2☒F	75 Yrs.			Sept. 11, 1925	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
422 Logan Street	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
C. Thurman Burgess	Lyda A. Kelly

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Diane C. Yingling, Daughter	2653 Park Mills Road, Adamstown, Md. 21710

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resthaven Memorial Gardens,	July 22, 2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard E. Gray M00255	Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	TWO WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES-000	JULY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SABRINA TOM JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	▶ Brenda B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Thelma	Virginia	WARNER	JULY 10, 2001	10:27 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-32-8043	1☐ M 2☒ F	87 Yrs.			Dec. 11, 1913	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
423 Columbia St.	21502	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Home maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Robert Hall	Nannie Remmel

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Wilkinson/ Son	423 Columbia St. Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	North Fork Memorial	7/12/2001	Riverton, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ S. Mark Sipp	Upchurch Funeral Home, P.A. 202 ~~Greene St. Cumb.,~~ MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	MYOCARDIAL INFARCTION	3 WEEKS
Due to (or as e consequence of): b.	PEPTIC ULCER DISEASE	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	THORACIC ANEURYSM	3 years
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D36766	July 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Vik Poorai MD. 924 Seton Dr. Cumberland, Md. 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 13 2001	Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

WARNER, THELMA SS# 212-32-8043

5

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KAYE ZINN

2. Date of Death: Month 7 Day 15 Year 2001

3. Time of Death: 00:30 M

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 176-26-0208

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): SEPT. 2, 1935

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: PA

10b. County: Adams

10c. City, Town or Location: NEW OXFORD

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 196 South Hickory LANE

10f. Zip Code: 17350

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME HEALTH CARE Aid

18b. Kind of Business/Industry: VISITING NURSE ASSOC. COMMUNITY HEALTH SERVICE

17. Father's Name (First, Middle, Last): FRANCIS IVAN STAHL

18. Mother's Name (First, Middle, Maiden Surname): PAULINE STRAUSBAUGH

19a. Informant's Name/Relationship (Type, Print): KATRINA WRIGHT DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6721 Chambersburg Rd. FAYETTEVILLE, PA 17222

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ANNUNCIATION CEMETERY

Date: July 19, 2001

20c. Location - City or Town, State: McSherrystown, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: ECKHARDT FUNERAL CHAPEL 11605 REISTERSTOWN Rd. OWINGS MILLS, MD 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Primary Biliary Cirrhosis — Approximate Interval Between Onset and Death: 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): b. Hepatorenal Syndrome — 2 months

Due to (or as a consequence of): c. ___

Due to (or as a consequence of): d. ___

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ___ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: P13365

29d. Date signed (Month, Day, Year): 7/15/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jolene Brown, MD 22 South Greene Street UNIVERSITY OF MARYLAND MEDICAL SYSTEM Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WJR 15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ida Mae Allen

2. Date of Death: Month July Day 27 Year 2001

3. Time of Death: 7 PM

4e. Facility Name (If not Institution, give street and number): Stella Maris Hospice @ Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-24-4475

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-28-22

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 7188 McClean Blvd.

10f. Zip Code: 21234

10g. Citizen of What Country: USA

11. Marital Status: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade | College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Laundry Company

17. Father's Name (First, Middle, Last): Will Allen

18. Mother's Name (First, Middle, Maiden Surname): Katie Holden

19a. Informant's Neme/Reletionship (Type, Print): Carrie Allen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 Pickering Drive Apt."E" Baltimore, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion Cemetery | Date: 08-02-01

20c. Location - City or Town, State: Lansdowne, MD

21. Signeture of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errast, shock, or heert failure. List only one ceuse on eech line. (Approximate Interval Between Onset and Deeth)

Immediate Ceuse (Finel disease or condition resulting in death): a. Respiratory Failure

Due to (or as a consequence of): b. End stage metastatic disease of

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es e consequence of): c. unknown primary cancer

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I. Squamous cell cancer of labia. Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: [signature]

29c. License number: D40854

29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DAVID RISEBERG 30 1/ST PAUL PL BALTIMORE MD 21202

State Registrar

31. Dete filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24240

AMEND ITEM #23 PER PHY G798 8/28/01 JH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Eddie B. Barlow	July 31 2001	5:10 A.M.

4a. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare Hammonds Lane	Baltimore	Anne Arundel

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	6. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214 16 9402	1☒ M 2☐ F	83 Yrs.			Dec. 16, 1917	Virginia

Funeral Director

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Glen Burnie	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6801 Rapid Water Way #101	21060	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Seed Processor	Southern States Farm Supplies

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Samuel Barlow	Bessie Dimue

19a. Intormant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Slete, Zip Code)
Edith Resuta / Daughter	402 Rugby Avenue Baltimore, Maryland 21225

20a. Method ot Disposition	20b. Place ot Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	8/3/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Donna M Zramiewski	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one causa on each line.

		Approximata Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration PNEUMONIA	1 month
	Due to (or as a consequence ot):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Infected Sacral decubitus	2 wks
	Due to (or es a consequence ot):	
	c. Advanced Alzheimer's Dementia	years
	Due to (or as a consequence ot):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion ot causa of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place ot Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)	28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
MD	D54736	7/31/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Kam Anyeng 7845 Oakwood Road Suit 100, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	Barbara B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#23

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine E Bryl

2. Date of Death — Month: July Day: 25 Year: 2001

3. Time of Death: 5:55AM

4a. Facility Name (If not Institution, give street end number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219 14 1804

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): June 9, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Ferndale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 307 Ferndale Avenue

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Wards Dept. Store

17. Fether's Neme (First, Middle, Last): George Grouling

18. Mother's Name (First, Middle, Meiden Surneme): Ella Orash

19a. Informent's Neme/Reletionship (Type, Print): John Bryl / Husband

19b. Meiling Addrass (Streat end Number or Rural Route Number, City or Town, State, Zip Code): 307 Ferndale Avenue Ferndale, Maryland 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel trom Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetary, crametory or other piece): Holy Cross Cemetery

Date: 7/28/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Sharron Liggett

22. Name end Address ot Fecility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiretory arrast, shock, or heert tailure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death) a.	Cellulitis with Sepsis	1 Week
Due to (or es a consequence of): b.	Metastatic Lung Cancer	2½ yrs.
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or tnjury that initiated events resulting in death) Last — Due to (or es e consequence of): c.		
Dua to (or as a consequanca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cholestatic Jaundice, Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Death (Check only one) — Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of tnjury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, term, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, tn my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Russell C. Delaney MD

29c. License number: D31551

29d. Date signed (Month, Dey, Year): July 25, 2001

30. Name end address ot person who completed cause of death (Item 23a) (Type, Print): Russell C. Delaney MD 1600 S. Crain Highway Glen Burnie, Md. 21061

State Registrar

31. Date tiled (Month, Day, Year): AUG 1 - 2001

32. Registrer's Signeture: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Catherine E Bryl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24242

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie Lillian Buckler

2. Date of Death: Month July Day 26 Year 2001

3. Time of Death: 5:00 P. M

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Hammonds Lane

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218 26 4748

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 28, 1915

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 613 Hammonds Lane

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): August Henry Krach

18. Mother's Name (First, Middle, Maiden Surname): Amanda Anna Gibson

19a. Informant's Name/Relationship (Type, Print): Brenda Lowe / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2918 New York Avenue Baltimore, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial

Date: PK. 7/30/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna Bramiowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Bronchopneumonia — Due to (or as a consequence of): — July 13, 2001

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer Type Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☑ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case relerred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Colvin Carter MD

29c. License number: D01459

29d. Date signed (Month, Day, Year): July 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Colvin Carter 4710 Pennington Ave Balto, Md. 21226

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001

32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 26,27 per phys G797080101 SS

Certificate of Death

Reg. No. 2001 24243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Michael Nicholas Bolton, Sr.	July 25, 2001	2:00P[M]

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7244 Gough Street	Colgate	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-34-4401	1☒M 2☐F	63 Yrs.			March 15, 1938	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Colgate	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7244 Gough Street	21224	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years		Ship Line Handler	Shipping

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Bolton	Helen Guggen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Sharon L. Bolton (Wife)	7244 Gough Street Baltimore, Maryland 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	7/30/2001	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Hx of atrial fibrillation	5 yrs
	Due to (or as a consequence of): c. Hx of coronary artery blockage since	1997-8yrs
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wilarda V Edwards MD	D21696	07/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wilarda V Edwards, 1005 North Point Blvd, Ste 724 Balto MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG - 1 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#31 PR. DVR 8-1-01JB

Certificate of Death

Reg. No. 2001 24244

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
IRVING	BASS	JULY 30 2001	6:55 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MILFORD MANOR NURSING HOME	BALTIMORE	BALTIMORE

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-07-7024	1 X M 2 ☐ F	88 Yrs.			OCT 12 1912	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4204 OLD MILFORD MILL ROAD	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		SALESMAN	MONUMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HYMAN BASS	JENNIE TONEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. SIDNEY BASS/ SON	9767 NORTH 117TH STREET SCOTTSDALE, ARIZONA 85259

20a. Method of Disposition	20b. Place of Disposition (Name of Cemetery, Crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	PROGRESSIVE BENEFIT & RELIEF ASSOC	7/31/01	ROSEDALE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert Levinson	SOL LEVINSON & BROS. INC, 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerosis	15 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of prostate
Hyperthyroidism
Alzheimer's Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jerome H. Ginsberg M.D.	#d0020964	7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome H. Ginsberg M.D. 8630 Liberty Plaza Mall Randallstown MD 21136

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
~~7/30/01~~ AUG 0 1 2001	Jerome B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): INEZ BROWN

2. Dete of Deeth — Month: JULY Dey: 25 Yaer: 2001

3. Time of Death: 11:40am

4a. Facility Nama (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location ol Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 231-22-0855

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Yeer — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): OCTOBER 11, 1921

9. Birthplace (State or Foraign Country): unk

Usual Residenca ot Decedent

10a. Stata: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 6040 Harford Road

10f. Zip Coda: 21214

10g. Citizan ot Whet Country?: USA

11. Marital Status: unk
1☐ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No
It Yas, Giva Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)
1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, Whita, etc.
Specify: black

15. Decedent's Education (Specify only highast grada complatad)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): unk

16b. Kind ot Business/Industry: unk

17. Fether's Neme (First, Middle, Last): unk

18. Mothar's Nama (First, Middla, Maiden Surnema): unk

19a. Intormant's Name/Ralationship (Type, Print): Good Samaritan Hospital

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code): 5601 Loch Raven Blvd Baltimore, MD 21239

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donalion 5☒ Other (Specify) in state

20b. Placa ot Disposition (Nama of cemetery, crematory or othar place):

Data:

20c. Location - City or Town, Stete:

21. Signatura of Funaral Service Licansee: Ronald S. Wade, Director

22. Nama and Addrass of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter tha moda ol dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only ona causa on aach lina.

Approximate Interval Batween Onsat and Death

Immediata Causa (Final diseese or condition resulting in death):
a. ASPIRATION PNEUMONIA
Dua to (or as a consequanca of):

Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated evants resulting in daath) Last
b.
Due to (or as e consequanca ot):
c.
Dua to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
CORONARY ARTERY DISEASE
HYPERTENSION RELATED END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Wara autopsy findings eveilabla prior to completion of cause ot deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examinar? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mannar ot Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Data ot Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred:

28e. Plece ot Injury - At homa, term, street, factory, offica building, atc. (Specify):

28f. Location (Straat and Number or Rurel Route Number, City or Town, Stete):

29a. Cartifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and placa, and dua to the ceuse(s) and mennar as stated.
2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and pleca, end dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: MD

29c. Licansa number: P13453

29d. Data signed (Month, Day, Year): July 25, 2001

30. Nama and addrass of person who complated causa ot daath (Item 23a) (Type, Print): GONLALO GIANELLA MD. 5601 Loch Raven Blvd.

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signatura: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24246

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Russell Frank Bell, Sr.	July 16, 2001	8:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Tokoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
251.24.6050	1☒M 2☐F	81 Yrs.			May 13, 1920	Lancaster, S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D. C.		Washington,	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5600 3rd. Street, N. W.	20011	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4years	Manager	IBM Corp.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Bell	Delphine Brevard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edith K. Bell - Wife	5600 3rd. Street,NW. Washington, D. C. 20011

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ft. Lincoln Cemetery	July 21, 01	Bladensburg, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven Latney Sr CC0348	Latney's Funeral Home 3831 Georgia Avenue, N.W. Washington,D.C.20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myo Cardial Infarction	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Left Ventricular Aneurysm	
	Due to (or as a consequence of):	
	c. Cerebrovascular Accident	
	Due to (or as a consequence of):	
	d. Hypertension	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Steven Tee MD	D46998	7/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Tee MD 3415 HAMILTON ST Hyattsville MD 20782

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
AUG 1 - 2001	▶ Penny D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1PER PHY G798 8 *Certificate of Death*

Reg. No. 2001 24247

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert T. ~~Burger~~ BERGER	July 26, 2001	00:57 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Adventist Hospital Washington	Takoma Park	Montgomery

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578.36.3675	1☒M 2☐F	73 Yrs.			Jan.29.1928	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D. C.		Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1345 Perry Place, N.W.	20010	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th.		Foreman Warehouse	Merchandise

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unavailable	Della Kate Burger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Susan K. Berger - Daughter	1345 Perry Pl.,NW Washington, DC 20010

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	FT Lincoln Cemetery	7/31/01	Bladensburg, MD

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶ [signature]	CC0348	Latney's Funeral Home, Inc. 3831 Georgia Ave.,NW, Washington, DC 201

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Colon Cancer

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ James K Lightfoot, Jr M.D	52326	7/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James K. Lightfoot Jr M.D. 7600 Carroll Ave Takoma Park MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	▶ [signature] D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gene R. Caulfield

2. Date of Death: Month July, Day 25, Year 2001

3. Time of Death: 4:30 A.M.

4a. Facility Name (If not institution, give street and number): Genesis Eldercare severna Park Center

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212 30 0020

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Oct. 28, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1300 Washington Blvd. Apt. 211

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): UNKNOWN; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sanitation Dept. Maint.

16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Francis S. Caulfield

18. Mother's Name (First, Middle, Maiden Surname): Sadie E. Cord

19a. Informant's Name/Reletionship (Type, Print): Howard D. Caulfield Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1605 Kimber Road Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Hill Cemetery

Date: 7/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Brominski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List anyone cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Lung Cancer — 2months

Due to (or as e consequence of):

b. Brain Metastases of lung cancer — 2months

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causs of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es stated. 2☐ **Medicel Examiner**: On the basis of examinetion and/or investigation, In my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: John F Loome, MD

29c. License number: D52728

29d. Date signed (Month, Dey, Year): July 25, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): John F. Loome, M.D. 479 Jumpers Hole Road #304 Severna Park, MD 21146

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 1 - 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNIE CROWELL
2. Date of Death (Month, Dey, Year): 7 - 30 - 2001
3. Time of Death: 5 35 AM
4a. Facility Name (If not institution, give street and number): FUTURE CARE HOMEWOOD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-30-2306
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-6-1912
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2700 N. CHARLES ST.
10f. Zip Code: 21218
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade — College (1-4or 5+): NO
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): HENRY FORMAN
18. Mother's Name (First, Middle, Maiden Surname): MARY UPSHUR

19a. Informant's Name/Relationship (Type, Print): John Crowell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1318 N. POTOMAC ST. BALTO. MD. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cem
Date: 8-2-01
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Patricia Butts
22. Name and Address of Facility: Butts Funeral Home 1129 N. Caroline ST. BALTO. MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Severe Dementia — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christopher Price M.D.
29c. License number: D43564
29d. Date signed (Month, Day, Year): July 31, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CHRISTOPHER PRICE M.D. 201 E. UNIVERSITY PKWY BALTO, MD 21218

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: Jennie G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

2001 24250

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sarah Chambers				2. DATE OF DEATH (Month, Day, Year): 07 23 2001	3. TIME OF DEATH: 8 36 A M
4. SOCIAL SECURITY NUMBER: 001-12-4587	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 04/19/1925	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Brighton Manor Nursing Cent.			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1501 N. Dukeland Street		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IH U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: black

15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4 or 5+): unk	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unk	16b. KIND OF BUSINESS/INDUSTRY: unk	
17. FATHER'S NAME (First, Middle, Last): unk		18. MOTHER'S NAME (First, Middle, Maiden Surname): unk	
19a. INFORMANT'S NAME (Type/Print): Brighton Manor		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 N. Dukeland Street Baltimore, MD 21216	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): in state	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S. Wade, Director		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastetic cervical Carcinoma	3 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. H/o vesico-vagino-Rectal Fistula	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Schizophrenia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Amatun H Haeem MD	29c. LICENSE NUMBER: D 15503	29d. DATE SIGNED (Month, Day, Year): ▶ July 26, 2001
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AMATUH N HAEEM 501 Dolphin st Balto MD 21217		
31. DATE FILED (Month, Day, Year): AUG 0 1 2001	32. REGISTRAR'S SIGNATURE: Geneva G Sparks	

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24251

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Erlene Joetta Trahan Collison
2. Date of Death: Month July, Day 20, Year 2001
3. Time of Death: 9:30 a.m.
4a. Facility Name (If not institution, give street and number): 707 Island Creek Road
4b. City, Town, or Location of Death: Church Hill
4c. County of Death: Queen Annes

Funeral Director

5. Social Security Number: 536-44-4058
6. Sex: 1☐ M 2☒ X
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 17, 1946
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Annes
10c. City, Town or Location: Church Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 707 Island Creek Road
10f. Zip Code: 21623
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, Whita, etc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Food Service

17. Father's Neme (First, Middle, Last): Joseph Trahan
18. Mother's Name (First, Middle, Maiden Sumame): Dolores Loretta Panatone

19e. Informent's Name/Relationship (Type, Print): Ronald L. Collison (Husband)
19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 707 Island Creek Road, Church Hill, MD 21623

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Metro Crematory
Date: 7/27/01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funerel Service Licensee: Thomas N Hardesty
22. Name end Address of Facility: Hardesty Funeral Home, P.A., 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immedlete Cause (Finel disaesa or condition resulting in death) e. Congestive Heart Failure — IMMEDIATE

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest

b.

Due to (or as e consequence of):

c.

Dua to (or es e consequence of):

d.

Part fl. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part f.: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner steted.

29b. Signature end title of certifier:
29c. License number: D0005754
29d. Date signed (Month, Day, Year): 7-25-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Ralph E. Libby, MD, Grasonville Medical Center, 204 Medical Ctr. Rd., Grasonville, MD 21638

State Registrar

31. Dete filed (Month, Dey, Year): AUG 1 - 2001
32. Registrer's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clifford E. Dixon
2. Date of Death (Month, Day, Year): July 31 2001
3. Time of Death: 2:15AM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium.
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 226-16-1039
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 28, 1917
9. Birthplace (State or Foreign Country): Virginia.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 5704 C Loch Raven Blvd
10f. Zip Code: 21239
10g. Citizen of What Country? USA.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
16b. Kind of Business/Industry: Black + Decker.

17. Father's Name (First, Middle, Last): Gaines V. Dixon
18. Mother's Name (First, Middle, Maiden Surname): Lena E. Hayes

19a. Informant's Name/Relationship (Type, Print): Ralph Dixon - brother.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Bayview Ct., Berlin MD 21811

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel - Bel Air MD
Date: 8/1/01
20c. Location - City or Town, State: Forest Hill, MD

21. Signature of Funeral Service Licensee: Krista S. Wells.
22. Name and Address of Facility: EVANS FUNERAL CHAPEL 8800 HARFORD RD Baltimore, MD 21234.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Prostate Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably X ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Hospice

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001
32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020 July 31, 2001 2:15 a.m.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Clifford Dixon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Leota Dorf
2. Date of Death Month: JULY Day: 28, Year: 2001
3. Time of Death: 2:00A M
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 351-18-0492
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 18 1924
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8810 Walther Blvd #225
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: Charlestown General

17. Father's Name (First, Middle, Last): James Leo Ryan
18. Mother's Name (First, Middle, Maiden Surname): Leota K. Kissel

19a. Informant's Name/Relationship (Type, Print): Debra Interior
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3721 Fox Ford Stream Rd Baltimore, Md 21236

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel Baltimore
Date: July 29 2001
20c. Location - City or Town, State: Forest Hill, Md

21. Signature of Funeral Service Licensee: Keista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): NON HODGKINS LYMPHOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. ____ Due to (or as a consequence of):
b. NEUTROPENIA Due to (or as a consequence of):
c. ____ Due to (or as a consequence of):
d. ____

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ____ 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Joginder P Mehta M.D
29c. License number: D 41410
29d. Date signed (Month, Day, Year): July 29th, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001
32. Registrar's Signature: Jenna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

NON HODGKINS LYMPHOMA

NEUTROPENIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
GRACE DORMAN			July 31 2001	7:30 A.M.
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
HOWARD COUNTY GENERAL HOSPITAL	COLUMBIA		HOWARD	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-28-3999	1☐ M 2☒ F	73 Yrs.			DEC 19, 1927	VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3915 BONNER ROAD	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12th	0	NURSE	HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
JOHN SMITH	ANNABELL SMITH

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
JOHN DORMAN-EL (SON)	3915 BONNER ROAD BALTIMORE, MD 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GARRISON FOREST VET.	8/3/01	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Brandon M. Wylie	WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. Septic shock	1 day
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal deeth 3☐ Ectopic pregnency 4☐ Pregnant et time of deeth 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure, pneumonia, diabetes mellitus, anoxic encephalopathy

23e. Did tobecco use contribute to the cause of death?	24e. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD, FCCP	D36845	July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI-CHI NGUYEN, MD, FCCP
7350 grace Drive, Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	Jeanne D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNE MARIE DEGRAVES

2. Date of Death: Month 07 Day 22 Year 01

3. Time of Death: 10:55 PM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212443354

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/28/1943

9. Birthplace (State or Foreign Country): BALTIMORE

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1801 WENTWORTH ROAD/GENESIS PERRING PKWY

10f. Zip Code: MD 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: greenhouse

17. Father's Name (First, Middle, Last): Elmer Baranowski

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Genesis Perring Parkway

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1801 Wentworth Road Baltimore, MD 21234

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, Md 21201

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COPD with resultant respiratory failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d. Renal Failure

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dominique Mall, M.D.

29c. License number: P13455

29d. Date signed (Month, Day, Year): 07/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOMINIQUE MALL, GOOD SAMARITAN 5601 LOCH RAVEN BOULEVARD BALTIMORE MD 21239

State Registrar

31. Date filed (Month, Day, Year): AUG - 1 2001

32. Registrar's Signature: Geneva D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #30 PER DVR G798 8/08/01 JH

Certificate of Death

2001 24256
Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)	ELEANOR		FISCHER	2. Data of Death Month / Day / Yaar	JULY 28 2001
3. Tima of Daath	1536 M				
4a. Facility Nama (If not institution, give street and number)	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	4b. City, Town, or Location of Death	BALTIMORE	4c. County of Deeth	
5. Social Security Number	214-07-5993	6. Sex 1☐M 2☒F		7. Aga (In yrs. last birthday)	87 Yrs.
If Undar 1 Year: Months / Days; If Undar 24 Hrs.: Hours / Min.		8. Data of Birth (Month, Day, Yaar)	Apr 21, 1914	9. Birthplace (State or Foreign Country)	Maryland

Usual Rasidance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD		Baltimore	1☒Yas 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizan of Whet Country?
1903 Wareham Road	21222	USA

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forces?	13. Was Dacedant of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, White, atc.
unk 1☐Navar Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yas, Giva Yaar or Datas:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	clerical	manufacturing

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
Lawrence Beal	Mollie Miller

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eleanor Fischer (donor)	1903 Wareham Road Baltimore, MD 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other placa)	Data	20c. Location - City or Town, Stata
1☐Burial 2☐Cremation 3☐Removal from Stata 4☒Donation 5☐Other (Specify)			

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disaasa or condition resulting in daath)	a. aspiration pneumonia	4 days
Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or injury thet initiated events rasulting in daath) Last	Due to (or as e consequence of): b.	
	Due to (or as a consequence of): c.	
	Dua to (or as a consequanca of): d.	

IF FEMALE: 23b. Wes decedent pregnant in tha pasl 12 months?	23c. If yes, outcome of pragnancy	23d. Data of delivary
1☐Yas 2☒No 9☐Unknown	1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. Dther **significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24e. Was en autopsy performed?	24b. Were autopsy findings availabla prior to completion of causa of daath?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case raferred to medical axaminer?	26. Placa of Daath (Check only one)	
1☐Yas 2☒No	Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Rasidanca 8☐Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurrad
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Placa of Injury - At horna, tarm, straet, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one) 1☒**Certifying Physician:** To tha best of my knowledga, death occurred at the tima, date and placa, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar statad.

29b. Signatura and title of certifiar	29c. License number	29d. Date signed (Month, Day, Year)
MD	RES-000	JULY 28 2001

30. Name and address of person who comptated cause of death (Item 23a) (Type, Print)

DR. SUAN LEE JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
AUG 01 2001	Geneva D Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
SHARON ADCOCK FINK	07 / 31 / 01	0200AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY OF MARYLAND	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-88-5545	1☐M 2☒F	39 Yrs.			Feb. 15, 1962	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Lansdowne	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3300 Bero Rd.	21227	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Food Service	Education System

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edwin Adcock	Agnes Gillen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lawrence Fink, Jr., husband	3300 Bero Rd. Lansdowne, MD. 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Meadowridge Memorial	08-03-01	Elkridge, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Rebecca Robinson M01254	Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
RESIDENT	AU4176435 R1250	7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIMAL G. RAMI 22 South Greene St. Baltimore, MD 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RR

RR 5

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 1 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #8 PER FH G798 8/01/01 JH

Certificate of Death

Reg. No. 2001 24258

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): William E. Flock
2. Data of Death — Month: JULY Day: 28 Year: 2001
3. Tima of Death: 7:25 PM
4a. Facility Nama (If not institution, giva street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-12-5037
6. Sex: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): MARCH 25 1922
9. Birthplaca (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stata: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Insida City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7817 Chestnut Ave.
10f. Zip Coda: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No — If Yes, Giva Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+): —
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): fork lift deiver
16b. Kind of Businass/Industry: Western Electric

17. Father's Nama (First, Middle, Last): John C Flock
18. Mothar's Nama (First, Middle, Maiden Surname): Gladys Lambert

19a. Intormant's Name/Ralationship (Type, Print): John L. Flock
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 2107 Hampton Ct. Fallston Md 21047

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Name of cemetary, cramatory or othar placa): Moreland Mem Park
Data: Aug 2001
20c. Location - City or Town, State: Parkville Md

21. Signature of Funeral Service Licensee: Linda L Wells
22. Nama and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused tha daath. Do not antar tha moda ot dying, such as cardiac or respiratory arrast, shock, or heart feilura. List only one ceuse on aach line. — Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death): a. End Stage Dementia

Dua to (or as a consaquanca ot):

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Dua to (or as a consaquanca ot):

c. Due to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to complation ot causa ot daath? 1 [ ] Yas 2 [ ] No

25. Was casa refarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowladga, death occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Data signed (Month, Day, Year): 7/31/01

30. Name and address of person who complatad causa ot daath (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

State Registrar

31. Data filad (Month, Day, Year): AUG 01 2001
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FLOCK, WILLIAM

AMENDED ITEM#23a per phys G798 080101 ss

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#2,29d Per Phy. 6/18/01 AACO HLTH cmh **Certificate of Death**

Reg. No. 2001 24259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ANN MARGARET FISCHER

2. Date of Death Month/Day/Year: ~~6/13/01~~ June 13, 2001 — Time of Death: ~~1205p~~ M

4a. Facility Name (If not institution, give street and number): UNIV. OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE, MD

4c. County of Death:

Funeral Director

5. Social Security Number: 148-44-7963

6. Sex: 1☐M 2☒F

7. Age (If yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 10, 1951

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 506 Narborough Court

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1972-1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Arthur Fischer

18. Mother's Name (First, Middle, Maiden Surname): Mary M. Galvacky

19a. Informant's Name/Relationship (Type, Print): Mary Fischer/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Narborough Court Severna Park, MD 21146

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Bernards Cemetery

Date: June 18, 2001

20c. Location - City or Town, State: Somerville, NJ

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ~~Sepsis and secondary acidosis~~ ~~metabolic~~

Due to (or as a consequence of): METABOLIC ACIDOSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. ~~Cutaneous T cell Lymphoma~~

Due to (or as a consequence of): CUTANEOUS T CELL LYMPHOMA

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 13127

29d. Date signed (Month, Day, Year): ~~6/13/01~~ June 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunita Koshy, M.D., 22 South Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 18 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ELIZABETH KERINA GETZEN	JULY 25 2001	20:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GOOD SAMARITAN HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
457-95-4208	1☐M 2☒F	33 Yrs.			11-18-1967	NAMIBIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
5207 BARBARA AVENUE	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☑Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE	2 YRS	NURSING ASSISTANT	HEALTH CARE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EMMANUEL KAVAA	ISABELLA KERINA

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ISABELLA KERINA / MOTHER	5207 BARBARA AVE., BALTO. MD. 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METRO CREMATORY	01-30-2001	BALTO. MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vaughn C	CREMATION SERVICES 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC CARCINOMA OF BREAST	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Dey / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ron Rosen, MD	RES-P13458	JULY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RON SHALOM ROSEN Good Samaritan Hospital 5601 Loch Raven Blvd, BALTIMORE

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 01 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert T. Gallion	July 25 2001	7:30 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
308 Riverside Drive	Pasadena	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216 24 4808	1☒M 2☐F	72 Yrs.			Sept. 10, 1928	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
308 Riverside Drive	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Lift Operator	Syrup Manufacturer

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Charles T. Gallion	Marie R. Moran

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marion C. Gallion / Sister	308 Riverside Drive Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Glen Haven Memorial Cem.	7/28/01	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Zgraniczouski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Lung CA.	6mo.
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or es e consequence of):	
	d. Due to (or es e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

Emphysema

23e. Did tobecco use contribute to the cause of deeth? 1☑Yes 2☐No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
	D31322	7/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bradley Craig MD 4304 MTN. Rd., PASADENA, Md 21122

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	Jennifer G. Spader

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MIRIAM V. GONTRUM
2. Date of Death: Month July Day 30 Year 2001
3. Time of Death: 7:05 AM
4a. Facility Name (If not institution, give street and number): Somerville Assisted Living At Westminster
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 189-07-1439
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 10, 1913
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 705 Camberley Circle Apt. A16
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
18b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Samuel Bankert
18. Mother's Name (First, Middle, Maiden Surname): CORA

19a. Informant's Name/Relationship (Type, Print): William H. Gontrum, JR-Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 Camberley Circle, Apt. A16 Towson MD 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery Date: 8-1-01
20c. Location - City or Town, State: Catonsville MD

21. Signature of Funeral Service licensee: Krista J. Wells
22. Name and Address of Facility: Timonium MD 21093. Evans Funeral Chapel 2325 York Rd.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. metastatic breast cancer — Approximate Interval Between Onset and Death: 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40850
29d. Date signed (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YVONNE OTTAVIANO 355 S. Center St. Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001
32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24263

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR JAMES GARHARTT

2. Date of Death — Month: JULY; Day: 31; Year: 2001

3. Time of Death: 2:20 AM

4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death: FOREST HILL

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 069-05-2556

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug.191917

9. Birthplace *(State or Foreign Country)*: Newyork

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1800 Sandee Court

10f. Zip Code: 21040

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grede completed)* — Elementery/Secondery (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Arthur Garhartt Sr.

18. Mother's Name *(First, Middle, Maiden Surneme)*: Grace Roberts

19a. Intorment's Neme/Reletionship *(Type, Print)*: Francis Garhartt / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1800 Sandee Court Edgewood MD 21040

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, cremetory or other place)*: Metro Crematory Inc. — Date: 8/1/01

20c. Location - City or Town, Steta: Baltimore MD

21. Signeture of Funeral Sarvice Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD. 21221

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death)
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — Yeers

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest
b.

Due to (or es e consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)* — Hospitel: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*: NI

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as steted. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [illegible] MD

29c. License number: 39889

29d. Date signed *(Month, Day, Year)*: July, 31, 2001

30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print): 615 W. MACPHAIL RD / BEL AIR MD 21014

State Registrar

31. Dete filed *(Month, Dey, Year)*: AUG 1 - 2001

32. Registrer's Signetura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as tha burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPM
01-4273-025
WILLIE GATLING, SR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIE HERBERT GATLING SR
2. Date of Death (Month, Day, Yaar): JULY 28, 2001
3. Time of Death: 8:42 PM
4a. Facility Name (If not institution, give street and number): 1421 PERRYWOOD DRIVE
4b. City, Town, or Location of Death: ABERDEEN
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 237-38-4774
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 25 1926
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD CO
10c. City, Town or Location: ABERDEEN
10d. Inside City Limits: 1 Yas 2 XX No
10e. Street and Number: 1421 PERRYWOOD DRIVE
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 Married 3 XX Widowed 4 Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 XX Yes 2 No. If Yes, Give Yaar or Dates: 66/74
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 XX No. Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondery (0-12): 12th grade; College (1-4or 5+): 3yrs
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: HARFORD CO GOVERNMENT

17. Father's Nama (First, Middle, Last): WORDLY GATLING SR
18. Mother's Name (First, Middle, Maiden Surname): MARY SHARP GATLING

19a. Informant's Name/Relationship (Type, Print): Cheryl Gatling/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1337 Stockett Sq., Belcamp, Maryland 21017

20a. Method of Disposition: XX 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cametery, crematory or other placa): Harrellsville Cemetery. Data: 8/2/01
20c. Location - City or Town, State: Harrellsville, N.C.

21. Signature of Funeral Service Licensee: Charles K. Parrill
22. Name end Address of Facility: WILLIAM C BROWN COMMUNTIY FUNERAL HOME-HARFORD 321 S PHILADELPHIA BLVD ABERDEEN MD. 21001 P.A.

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Batwaen Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XX Unknown

24a. Was an autopsy performed? 1 ✓ Yes 2 No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No

25. Was case raferred to medical examiner? XX Yes 2 No

26. Place of Deeth (Check only one): Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA. Other: 4 Nursing Home 5 Residenca 6 XX Other (Specify) SCENE

27. Manner of Death: 1 ✓ Netural 2 Accident 3 Suicide 4 Homicide 5 Panding Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to tha cause(s) and manner as steted. 2 XX **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Melhuish
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JULY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYBARON D. KOPOK 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15-41

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND ITEM #3 PER PHY G 798 8/15/01 JH

Reg. No. 2001 24265

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM LEE GREENE JR

2. Date of Death Month / Day / Year: JULY 29 2001

3. Time of Death: 5:00 AM ~~unknown~~

4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS HOSPICE

4b. City, Town, or Location of Death: TIMONIUM

4c. County of Death: BALTIMORE CO

Funeral Director

5. Social Security Number: 212-16-4397

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 21 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HARFORD CI

10c. City, Town or Location: BELAIR

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1308 AGORA PLACE

10f. Zip Code: 21014

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 44/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CUSTODIAN

16b. Kind of Business/Industry: JANITORIAL

17. Father's Name *(First, Middle, Last)*: WILLIAM LEE GREENE SR

18. Mother's Name *(First, Middle, Maiden Surname)*: BERTHA GREENE

19a. Informant's Name/Relationship *(Type, Print)*: Beverly Greene/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1308 Agora Place, BelAir Md., 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BELAIR MEMORIAL GARDENS | Date: 8-3-01

20c. Location - City or Town, State: BELAIR, MARYLAND

21. Signature of Funeral Service Licensee: Charles J. Brown

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD 321 S PHILA BLVD, ABERDEEN MD 21001 P.A.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. *Approximate Interval Between Onset and Death*

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 1 - 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

July 29, 2001 5:00 a.m.
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

William Lee Greene
Division of Vital Records, P.O. Box 68760,

#3

CPM
01-3772-033
EUGENE GRAY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24266

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EUGENE GRAY

2. Date of Death: Month July Day 5, Year 2001

3. Time of Death: 12:18 PM

4a. Facility Name *(If not institution, give street and number)*: 4736 HOMER AVENUE APARTMENT D

4b. City, Town, or Location of Death: SUITLAND

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: unk

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 69 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar 16, 1932

9. Birthplace *(State or Foreign Country)*: unk

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4736 Homer Avenue #D

10f. Zip Code: 20746

10g. Citizen of What Country?: USA

11. Meritel Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No unk
If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondery (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk

16b. Kind of Business/Industry: unk

17. Fether's Name *(First, Middle, Last)*: unk

18. Mother's Neme *(First, Middle, Maiden Surname)*: unk

19a. Informant's Name/Relationship *(Type, Print)*: O.C.M.E.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 111 Penn Street Baltimore, MD 2101

20a. Method of Disposition
1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from State
4 [ ] Donation 5 [X] Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic

Due to (or as a consequence of):
b. Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Chronic Renal Disease
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE

27. Manner of Death
1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JULY 6, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): J. Lakin Lotz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG - 1 2001

32. Registrar's Signature: Penny P Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHILIP HASKINS.
2. Date of Death — Month: JULY Day: 30 Year: 2001
3. Time of Death: 11:04 AM
4a. Facility Name (If not institution, give street end number): GOOD SAMARITAN HOSP. 5601 Loch Raven BLVD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-10-6446
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 3, 1909
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND 10b. County: N/A 10c. City, Town or Location: BALTIMORE 10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 711 EAST 21ST STREET 10f. Zip Code: 21218 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 3 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST

16b. Kind of Business/Industry: KOPPERS CO

17. Father's Name (First, Middle, Last): JAMES WALKER HASKINS

18. Mother's Name (First, Middle, Maiden Surname): MARY ELIZABETH TURNOR

19a. Informant's Name/Relationship (Type, Print): JANIE HASKINS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 EAST 21ST STREET BALTO MD 21218

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD. NATIONAL MEM PK Date: 8/3/2001

20c. Location - City or Town, State: LAUREL, MD.

21. Signature of Funeral Service Licensee: ▶ Gloria Adams Jones

22. Name and Address of Facility: MARSHALL W. JONES, JR. FH. INC. 4101 Edmondson Ave. Balto. Md. 21229

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS.

Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
HIGH BLOOD PRESSURE
ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Katina Mair RESIDENT
29c. License number: P13965
29d. Date signed (Month, Day, Year): JULY 30 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KATINA MAIR GOOD SAMARITAN HOSPITAL GOOD SAMARITAN 5601 Loch Raven Blvd. BALTIMORE MD.

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: ▶ Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24268

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harry Leroy Hollingshead, Sr.
2. Date of Death (Month, Day, Year): July 27, 2001
3. Time of Death: 12:40 P
4a. Facility Name *(If not institution, give street and number)*: 7624 Old Battle Grove Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-10-5527
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 30, 1910
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7624 Old Battle Grove Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Crane Operator
16b. Kind of Business/Industry: Steel Industry

17. Father's Name *(First, Middle, Last)*: Elward Hollingshead
18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel D. Wilhelm

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Edna V. Hollingshead (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7624 Old Battle Grove Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gdns. | Date: 7/30/2001
20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: Gregory E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Renal Insufficiency — 1 Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Metastatic Prostate Cancer — 7 Years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Alan N. Dennis
29c. License number: D30555
29d. Date signed *(Month, Day, Year)*: July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan N. Dennis, M.D. 7566 North Point Road Baltimore, Maryland 21219

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 0 1 2001
32. Registrar's Signature: Dawn D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24269

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Virginia Elizabeth Hollenbeck	July 25 2001	1444 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
244-30-9986	1☐M 2☒F	76 Yrs.			Oct. 7, 1924	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Edgewater	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3307 Glebe Drive	21037	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Payroll Supervisor	Payroll

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Arthur B. Unknown	Lucy Ella Cannon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Arthur M. Hollenbeck (Son)	3307 Glebe Road, Edgewater, MD 21037

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	07/30/2001	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic obstructive pulmonary disorder	10yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Donna Chambers MD	D48101	7/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Donna Chambers MD 1833A Forest Dr. Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	▶ [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

JOHN F HULL
01-4191-043
RDC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24270

UNPENDED 082201:ITEMS#23a-ptI&II,27,28a-f per ME G798 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN FRANKLIN HULL

2. Date of Death: Month JULY Day 24 Year 2001

3. Time of Death: 2330 PM

4a. Facility Name (If not institution, give street and number): 12920 DRAPER ROAD

4b. City, Town, or Location of Death: CLEAR SPRING'S

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 219-07-4433

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 16, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Clear Spring's

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12920 Draper Road

10f. Zip Code: 21722

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): letter carrier

16b. Kind of Business/Industry: US Postal Service

17. Father's Name (First, Middle, Last): David Frank Hull

18. Mother's Name (First, Middle, Maiden Sumame): Mary Alice Miles

19a. Informant's Name/Relationship (Type, Print): Judith Weise/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 173 Kamberwood Court Gerrardstown, WV 25420

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Daath

Immediate Cause (Final disease or condition resulting in deeth): a. HEAD INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yas 2 [ ] No

26. Plece of Deeth (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year) Found: 7-24-01

28b. Time of Injury Found: 9:30p M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject fell

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify): residence

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): 12920 Draper Rd., Clear Spring, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

29b. Signatura and title of certifier: J. M. T.

29c. License number: OCME

29d. Data signed (Month, Dey, Year): JULY 25 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG - 1 2001

32. Registrar's Signature: Jennie P Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#20b perFHG798 8/9/01 EW

Certificate of Death

Reg. No. 2001 24271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jacqueline DOROTHEA ISENNOCK
2. Date of Death (Month, Day, Year): JULY 28 2001
3. Time of Death: 1:15AM
4a. Facility Name (If not Institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore.

Funeral Director

5. Social Security Number: 213-36-6891
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 12 1937
9. Birthplace (State or Foreign Country): Maryland.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2704 A Dunwall Ct.
10f. Zip Code: 21222
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): disabled
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): Daniel John BANKERD
18. Mother's Name (First, Middle, Maiden Surname): DOROTHEA Elsie NORWOOD
19a. Informant's Name/Relationship (Type, Print): Kellie M. Giordano-
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 443 Oakwood Rd., Baltimore MD 21222
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL - BELAIR, P.A.
Data: 7/30/01
20c. Location - City or Town, State: FOREST HILL, MD
21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name and Address of Facility: Baltimore, MD 21234. EVANS FUNERAL CHAPEL 8800 HARFORD RD

To Be Completed by Funeral Director

July 28, 2001 1:15 a.m.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D43721
29d. Date signed (Month, Day, Year): 7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

Medical Certification: To Be Completed by Physician/Medical Examiner

Jacqueline Isennock
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HERBERT A. JONES	07-28-2001	2:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GENESIS ELDER CARE	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-30-9823	1☑M 2☐F	67 Yrs.			08-24-1933	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
144 STONECROFT ROAD	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 TH GRADE	N/A	STEEL WORKER	BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
COLONEL JONES	AGNES ROSELLA JONES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANNIE MAE JONES / WIFE	2121 WINSOR GARDEN LN., BALTO. MD. 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	LOUDON PARK	08-01-01	BALTO. MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vaughn C [signature]	VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive heart failure	Unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Ischemic coronary artery disease	Unknown
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D27569	7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Heffleman 1838 Green Tree Rd

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 01 2001	▶ [signature] D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month / Day / Year)	3. Time of Death
Edward Howard Johns Sr.	July 28 2001	11:00 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8483 Arbutus Drive	Pasadena	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 09 5839	1☒ M 2☐ F	81 Yrs.			Sept. 19, 1919	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8483 Arbutus Drive	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Labor Advisor	Labor Relations

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James A. Johns	Helen M. Stinchcomb

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret M. Rizzo / Daughter	331 Edgewater Road Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Meadowridge Mem. Park	8/2/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Shannon Liggett	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. END STAGE PARKINSONS DISEASE	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, DYSPHAGIA RECURRENT ASPIRATION AND PNEUMONIAS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Usha Sitha INTERNIST MD	D51104	JULY 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USHA VEMULAKONDA 4710 PENNINGTON AVENUE BALTIMORE, MD 21226

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	Genevieve D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel L. Jenkins
2. Date of Death: Month July, Day 27, Year 2001
3. Time of Death: 10:40 pm
4a. Facility Name (If not institution, give street and number): 344 Marganza South
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 236-22-0605
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 20, 1911
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 344 Marganza South
10f. Zip Code:
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Restaurant

17. Father's Neme (First, Middle, Last): Arthur Edsel
18. Mother's Neme (First, Middle, Maiden Surname): Lou Unknown

19a. Informent's Neme/Reletionship (Type, Print): Mary A. Johnson (Daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 344 Marganza South, Laurel, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Lakemont Memorial Gardens | Dete: 07/30 2001
20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Fecility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one,cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death): a. CORONARY ARTERY DISEASE — YERS

Due to (or es e consequence of):

Sequentiatly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture and titie of certifier: Pritam S Saini
29c. License number: D 28998
29d. Date signed (Month, Day, Year): July 30 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): PRITAM S SAINI MD 9101 Cherry Lane Suite 211, LAUREL MD 20708

State Registrar

31. Dete filed (Month, Dey, Year): AUG 1 - 2001
32. Registrar's Signeture: Bernice D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERTHENA VICTORIA KEELS

2. Date of Death: Month JUL Day 24 Year 2001

3. Time of Death: 2:48 PM

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-14-8361

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 3, 1920

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5110 Baltimore National Pike

10f. Zip Code: 21229

10g. Citizen of Whet Country?: USA

11. Marital Status: unk
1☐Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indien, Bleck, Whlte, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

18b. Kind of Business/Industry

17. Father's Name (First, Middle, Last): James E. Paul

18. Mother's Name (First, Middle, Meiden Surneme): Irene A. Brown

19a. Informant's Name/Relationship (Type, Print): St Agnes Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 S. Caton Avenue Baltimore, MD 21228

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Date

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Ronald B. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — DAYS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: P-14445

29d. Date signed (Month, Dey, Year): JUL/24/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MANISH PANDYA, ST AGNES HEALTHCARE, BALTIMORE, MD.

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature

NAME KEELS, VICTORIA
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mabel L. Krause

2. Date of Death: Month 07 Day 28 Year 2001

3. Time of Death: 3:00 am

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Hammonds Lane

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-36-4155

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 20 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 215 W. Edgevale Rd.

10f. Zip Code: 21225

10g. Citizen of What Country? U.S.A

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Raca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Peter H. Starklauf

18. Mother's Name (First, Middle, Maiden Surname): Hattie M. Wagner

19a. Informant's Name/Relationship (Type, Print): M. Edward Krause Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 543 Fairmount Rd. Linthicum Md. 21090

20a. Method of Disposition: ☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park Date: 7/30

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: George D. Gonce

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Balto. Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)

a. Arterio sclerotic Coronary Occlusive Disease 4 years

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b.

Due to (or es e consequenca of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Chronic Renal Disease

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, snd due to the cause(s) and manner stated.

29b. Signature end title of certifier: Michael Schwartz

29c. License number: D19667

29d. Dete signed (Month, Day, Year): 07-28-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael Schwartz 7310 Ritchie Highway Suite 508 Glen Burnie, MD. 21061

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Logan

2. Date of Death: Month July Day 28 Year 2001

3. Time of Death: 2:00Am

4a. Facility Name (If not institution, give street and number): Lorien - Frankford

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-26-3736

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 100 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-29-1900

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 5009 Frankford Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: in & out of home

17. Father's Name (First, Middle, Last): Nathan Turpin

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Robinson

19a. Informant's Name/Relationship (Type, Print): Irene Ushery

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2434 W. Coldspring Lane Baltimore, MD. 21215

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 08-02-01

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Anemia

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth V. Loeb, M.D.

29c. License number: D0051552

29d. Date signed (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 21 Crossroads Drive Suite 330 Owings Mills Elizabeth V. Loeb

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24278

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joo Sook Kwon
2. Date of Death Month / Day / Year: July 30, 2001
3. Time of Death: 5:17 AM
4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-84-7538
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 27, 1907
9. Birthplace *(State or Foreign Country)*: Korea

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9015 Satyr Hill Road
10f. Zip Code: 21234
10g. Citizen of What Country?: Korea

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Korean

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Un Pang Lee
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Young Kwon / son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9015 Satyr Hill Road; Parkville, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem Garden — Date: 8/1/01
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc 1050 York Road Towson, MD 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: STROKE, HYPERTENSION, OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D52360
29d. Date signed *(Month, Day, Year)*: 7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KUBIR SANDHU 14356 GREENE TREE RD. SUITE 300 PIKESVILLE MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 1 - 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Leroy	Allen	Keck	July	24	2001	0015 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
070-28-5746	1☒M 2☐F	65 Yrs.			Nov. 6, 1935	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1205 Maddox Way	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1958-69	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Director Operations	Publishing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leroy W. Keck	Myrtle Smith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dena M. Keck (Wife)	1205 Maddox Way, Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Epiphany Episcopal	07/30/2000	Odenton, Maryland

21. Signature of Funeral Service Licensee ▶ Peter J. Hardesty

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D40715	7/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEVEN HEARNE, M.D. 106 MILFORD ST STE 305 SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	▶ Regina D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LEROY KECK 070-28-5746 654 7/26/01 6215-

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24280

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD KIRBY

2. Date of Death Month Day Year: JUNE 12, 2001

3. Time of Death: 7:50 AM

4a. Facility Name *(If not institution, give street and number)*: 1522 W. Lexington Street #1

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-36-6699

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: unk Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: unk

9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1522 W. Lexington Street #1

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? unk
1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*
Elementery/Secondery (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk

16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: unk

18. Mother's Neme *(First, Middle, Meiden Surneme)*: unk

19a. Informant's Name/Relationship *(Type, Print)*: Western District Police Dept

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: unk

20a. Method of Disposition
1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)*: in state

20b. Placa of Disposition *(Neme of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Hypertensive arteriosclerotic cardiovascular disease — 10 years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abdominal aortic aneurysm

23b. Did tobacco use contribute to the cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes an autopsy performed?
1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth?
1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner?
1 [✓] Yes 2 [ ] No

26. Piece of Death *(Check only one)*
Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [✓] Residenca 6 [ ] Other *(Specify)*

27. Menner of Deeth
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*:

28b. Time of Injury M:

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: At home

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*
1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) end menner as stated.
2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: MEDICAL DOCTOR

29c. License number: RES-001

29d. Date signed *(Month, Dey, Year)*: June 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAL MELAMED 600 North Wolfe Street Tower 110 Baltimore Maryland 21287

State Registrar

31. Date filed *(Month, Dey, Year)*: AUG - 1 2001

32. Registrar's Signature: Jennifer D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 24281
Reg. No.

1- For State Registrar AMEND ITEM #27 PER PHY G798 8/10/01 JH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY LEACH
2. Date of Death: Month 07 Day 28 Year 01
3. Time of Death: 4AM M
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL EMERGENCY
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-34-9422
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-08-1923
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Cherryhill
10d. Inside City Limits: 1☐Yes XX No
10e. Street and Number: 723 Roundview Rd.
10f. Zip Code: 21225
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12 th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Randolph Manning
18. Mother's Name (First, Middle, Maiden Surname): Bertha Graham

19a. Informant's Name/Reletionship (Type, Print): Benton Leach (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 723 Roundview Rd. Cherryhill, Maryland 21225

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.
Date: 8/2/2001
20c. Location - City or Town, Stete: Owingsmills, Maryland

21. Signature of Funeral Service Licensee: Dennis B. Caple
22. Name and Address of Facility: Dennis B. Caple Funeral Home P.A. 4601 York Rd. Balto., Md. 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE CARDIAC DYSRHYTHMIA — Approximate Interval Between Onset and Death: IMMED

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — YEARS
Due to (or as a consequence of):
c. DIABETES — YEARS
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BREAST CANCER

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☐No 3☐Probably 4☑Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☑Yes 2☐No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Menner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☑Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kelscha Glenn D.O.
29c. License number: H0057390
29d. Date signed (Month, Day, Year): 07/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KELSCHA GLENN D.O.; HARBOR HOSPITAL EMERG. DEPT, 3001 S HANOVER ST; BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: Emma B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

01-4228-005
B.K.S
SHARLIN LEWIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sharlin Walters Lewis
2. Date of Death: Month JULY Day 26, Year 2001
3. Time of Death: 1617 PM
4a. Facility Name (If not institution, give street and number): 2902 DUNMORE ROAD APT.D
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-40-6644
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 20 1942
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2902 Dunmore Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Clerk
16b. Kind of Business/Industry: Md. Dental Lab

17. Father's Name (First, Middle, Last): Charles Joseph Walters
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Kirtley

19a. Informant's Name/Relationship (Type, Print): Marnel Lewis (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 584 Mohegan Lake, NY 10547

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 7/28
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: Sharron Leggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JULY 27, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 1 2001
32. Registrar's Signature: L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Anthony Joseph Leone Sr.	July 31 2001	2:00 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5502 Park Road	Baltimore	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219 18 4567	1☒M 2☐F	74 Yrs.			March 24,1927	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5502 Park Road	21225	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7th		Service Station	Gasoline

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John V. Leone	Louise Brolato

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Audrey Leone / Wife	5502 Park Road Baltimore, Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Mem. Park	8/3/01	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic Renal Failure	7years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Diabetic Nephropathy	14 years
Due to (or as a consequence of):		
c.	Insulin-Requiring Diabetes	14 years
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia
Peripheral Vascular Insufficiency
Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Colvin Carter, MD	D01459	Aug. 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Colvin Carter 4710 Penning ton Ave., Baltimore, Md. 21226

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	▶ [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24284

30 JULY 01

06:10 LANZANO, RAFFAELE

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Data of Death (Month Day Year)	3. Time of Death
Raffaele Lanzano	July 30, 2001	6:10 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-36-9320	1☒M 2☐F	77 Yrs.			2-15-1924	Italy

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
8325 Lages Lane	21244	U. S. A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, White, etc.
1☐Nevar Married 2☒Married 3☐Widowad 4☐Divorced	1☐Yas 2☒No If Yas, Giva Yaar or Datas:	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada compiated)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Barber	Court House Barber Shop

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Name (First, Middla, Maiden Surnama)
Vincenzo Lanzano	Raffaela Palermo

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Mrs Concetta Lanzano (Wife)	8325 Lages Lane, Baltimore, Maryland 21244

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☐Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☒Other (Specify) Entombment	CrestLawn Maus.	8-2-01	Marriottsville, Maryland

21. Signatura of Funaral Sarvice Licensee	22. Nama and Addrass of Facility
▶ Wallace S. Brooks, Jr.	Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death)

a. End-Stage Cirhosis of the Liver — months

Dua to (or as a consequanca of):

b. Hepatitis C infection — years

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated evants resulting in daath) Last

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Wera autopsy findings available prior to complation of causa of daath?
1☐Yas 2☒No	1☐Yas 2☐No

25. Was case referred to medical examinar?	26. Place of Death (Check only ona)
1☐Yas 2☒No	Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA Othar: 4☐Nursing Homa 5☐Rasidance 6☒Othar (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describa how injury occurrad
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined		M	1☐Yas 2☐No	

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, daath occurrad at tha time, date and placa, and dua to tha causa(s) and manner as stated. 2☐**Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurrad at the time, date and placa, and due to tha causa(s) and mannar statad.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signad (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	July 30, 2001

30. Nama and addrass of person who compiated causa of daath (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
AUG 1 - 2001	▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24285

Lombardo

Michael

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Michael Lombardo		2. Date of Death (Month, Day, Year): July 28 2001	3. Time of Death: 5:00 PM
4a. Facility Name (If not institution, give street and number): Doctor Community Hospital	4b. City, Town, or Location of Death: Lanham	4c. County of Death: Prince George's	
5. Social Security Number: 220-07-9208	6. Sex: XX M 2 F	7. Age (In yrs. last birthday): 91 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 20, 1910	9. Birthplace (State or Foreign Country): New Jersey		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Glenn Dale	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3307 Glen Ave.	20769	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates: 28/62	1 Yes 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12): 12	College (1-4or 5+): 5+	Officer	Military USMC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Angelo Combardo	Angela Di Giacomo

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Florence A. Lombardo Wife	3307 Glen Ave. Glenn Dale Maryland 20769

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Arlington National Cemetery	Aug. 8, 2001	Arlington Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael L Belt	Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. Acute myocardial infarction — Sudden

Due to (or as a consequence of):

b. Atherosclerotic heart disease — decades

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

senile dementia, mild

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No	28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Peter M Schisler MD	D22780	7/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schisler MD 7500 Greenway Ctr. Dr. Greenbelt, Md 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	Deanna D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTIN LAGO

2. Data of Death (Month, Day, Year): July 30 2001

3. Time of Death: 930 PM

4a. Facility Name (If not institution, give street and number): COZY COUNTRY CORNER ASSISTED LIVING

4b. City, Town, or Location of Death: CHASE Md

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 099-26-3073

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): JAN 12 1913

9. Birthplace (State or Foreign Country): VA

Usual Residance of Decedant

10a. Steta: Md.

10b. County: BALTIMORE

10c. City, Town or Location: LUTHERVILLE, Md.

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3 LOCHMOOR COURT

10f. Zip Coda: 21093

10g. Citizan of What Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Yaer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yas 2 ☒ No Specify:

14. Race - American Indien, Black, White, atc. Specify: WHITE

15. Decedant's Education (Specify only highast grade completed)

Elementary/Secondary (0-12): 12

Collega (1-4or 5+): 4

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): ACCOUNTANT

16b. Kind of Businass/Industry: BETA SHOE

17. Fathar's Nama (First, Middle, Last): UNK

18. Mothar's Nama (First, Middle, Maiden Surnama): UNK

19a. Informant's Name/Ralationship (Type, Print): LINDA LAGO

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3 LOCHMOOR Ct. Lutherville, Md 21093

20a. Mathod of Disposition: 1 ☐ Burial 2 ☒ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or other placa): BAYVIEW CREM.

Data: 8/1/2001

20c. Location - City or Town, Stata: BALTO Md.

21. Signatura of Funaral Service Licensaa: Paul M. Stella

22. Nama and Address of Facility: HARTLEY MILLER FUNERAL HOME, LTD. 7527 HARFORD Rd. Balto Md 21234

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complicetions that caused the deeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Pneumonia — 2 WKS.

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Lest

b. Advanced Alzheimer's Dementia — 1 YR.

Dua to (or as a consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medical axaminar? 1 ☐ Yas 2 ☒ No

26. Placa of Death (Check only ona)

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☒ Other (Specify) ASSISTED LIVING

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending invastigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 ☒ **Certifying Phyeician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: [signature]

29c. Licensa number: D17728

29d. Data signed (Month, Day, Year): July 31, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236

State Registrar

31. Data filed (Month, Day, Year): AUG 1 - 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roosevelt Moore

2. Data of Death: Month July Day 29 Year 2001

3. Time of Death: 2149

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 230-10-9670

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 05-12-1920

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PIKESVILLE

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 4124 BONNIE BRAE ROAD

10f. Zip Code: 21208

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10 TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LONG SHOREMAN

16b. Kind of Business/Industry: SHIPPING

17. Father's Name (First, Middle, Last): WILLIE MOORE

18. Mother's Name (First, Middle, Maiden Surname): LUCILLE LEE

19a. Informant's Name/Relationship (Type, Print): ROXIE MOORE | WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4124 BONNIE BRAE RD., PIKESVILLE, MD. 21208

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): DULANEY VALLEY

Date: 08-04-01

20c. Location - City or Town, State: TIMONIUM, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of): b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dr. Laura Harlan

29c. License number: H005139

29d. Date signed (Month, Day, Year): July 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Northwest Hospital Dr. 5401 old Court Rd. Randallstown MD 21133 Dr. Laura Harlan

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001

32. Registrar's Signature: Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Ronnie Makell
01-2241-510
CJ
Unknown 01-089

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 080201:ITEMS#23a,27,28a-f G798 SS

Certificate of Death

Reg. No. 2001 24288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
RONNIE A. MAKELL	April	22	2001	10:42 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-86-6125	1[X] M 2[ ] F	32 Yrs.			Sept 26, 1968	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		Baltimore	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
510 N. Belnord Avenue	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	unk	unk
9	0		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Ronnie Makell	Celia Wright

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Celia Willis/mother	751 W. Saratoga Street #424 Baltimore, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1[ ] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donetion 5[X] Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I: Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown	23c. If yes, outcome of pregnency 1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnency 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probebly 4[X] Unknown

24e. Was en autopsy performed? 1[X] Yes 2[ ] No	24b. Were autopsy findings available prior to completion of cause of death? 1[X] Yes 2[ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medicat examiner? 1[X] Yes 2[ ] No

28. Place of Death (Check only one) — Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA — Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death: 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
found: 4-22-01	found: 10:15A M	1[ ] Yes 2[X] No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found: alley	200 E. North Ave., Balto., MD

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
	O.C.M.E.	April 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 1 2001	Debra D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma N. T. Merkel

2. Data of Death — Month: July Day: 27, Year: 2001

3. Time of Death: 5:00 PM

4e. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-01-0926

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 23, 1915

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 394 Butler Road

10f. Zip Code: 21136

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind ot Businass/Industry: Own Home

17. Father's Name (First, Middle, Last): George G. Teves

18. Mothar's Name (First, Middle, Maiden Surname): Sophie W. Knning

19a. Intormant's Name/Reletionship (Type, Print): Walter E. Merkel Son

19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code): 4 Silver Stirrup Ct., Timonium, MD 21093

20a. Mathod ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Othar (Specify)

20b. Place ot Disposition (Name of cemetary, cremetory or othar piece): Evergreen Memorial Gard.

Data: 7/30/01

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funaral Service Licensee: Frank B Eline

22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Road, Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not antar tha mode ot dying, such es cardiac or respiretory errest, shock, or heert failura. List only ona causa on aach lina. (Approximete Intarval Between Onset and Deeth)

Immediete Cause (Finel diseese or condition resulting in death): e. Peripheral Vascular Disease

Due to (or es e consequence ot):

Sequentially list conditions, if any, leeding to immadiate cause. Entar Underlying Cause (Disaase or Injury that initieted events resulting in death) Last

b.

Due to (or es e consequence ot):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion ot cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Plece of Deeth (Chack only ona) — Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time ot Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place ot Injury - At home, tarm, street, tactory, office building, atc. (Specify)

28f. Location (Straet and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledga, deeth occurred at tha tima, data and place, end due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis ot exeminetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to tha causa(s) and manner stated.

29b. Signeture and title ot certifier:

29c. Licensa number: D43725

29d. Date signad (Month, Day, Year): 7/31/01

30. Neme and address ot person who completed cause of deeth (Item 23e) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Data filed (Month, Day, Year): JUL 3 1 2001

32. Registrer's Signatura: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

July 27, 2001 5:00 p.m.
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Thelma N.T. Merkel
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24290

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA May Moore

2. Date of Death: Month JUL Day 30 Year 2001

3. Time of Death: 9:00 A M

4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-05-6424

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 27, 1918

9. Birthplace (State or Foreign Country): VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 221 Maiden Choice Lane Apt. B

10f. Zip Code: 21228

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Glass Company

17. Father's Name (First, Middle, Last): Howard F. Cunningham

18. Mother's Name (First, Middle, Maiden Surname): Anna Christine Patterson

19a. Informant's Name/Reletionship (Type, Print): June Calo, niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1409 Ridgemere Lane Winston Salem, NC. 27106

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Memorial Park

Date: Aug. 3, 2001

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Rebecca Robinson MA254

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. Metastatic Breast Cancer — Approximate Interval Between Onset and Death: 4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnency: 1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnency 4☐ Pregnent et time of deeth 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: Paul Gormley

29c. License number: D18587

29d. Dete signed (Month, Dey, Yeer): JUL 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Gormley 3350 Wilkens Ave Suite 100 Balto. MD 21229

State Registrar

31. Date filed (Month, Dey, Yeer): AUG 0 1 2001

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Anna May Moore

RR

RR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#23a per phys G798 080101 SS

Certificate of Death

Reg. No. 2001 24291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MARY	LOUISE	MARTIN	JUNE	16	2001	02:19 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-26-7730	1☐M 2☒F	64 Yrs.			July 3, 1936	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Havre de Grace	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
302 Squaw Court	21078	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Giva Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Twelve Years		C.E.O.	Mary L. Martin, Ltd. Perryville,Maryland

17. Fathar's Name (First, Middle, Last)	18. Mothar's Name (First, Middla, Maidan Surnama)
James L. Walker	Mary Sinclair

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Code)
William Thomas Napier Martin, IX	302 Squaw Court, Havre de Grace, Maryland 21078

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other piece)	Date	20c. Location - City or Town, Stete
☒Burial 2☐Cremetion 3☐Removal from Stata 4☐Donetion 5☐Other (Specify)	West Nottingham Cemetery	June 20,2001	Colora, Maryland

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
▶ Thomas M. Patterson, Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failura. List only one ceuse on each line.

Approximata Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death)

a. Multi organ system failure. — Approximata Interval: 10 days.

Sequentially tist conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as e consequence of):

b. SEPSIS

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings availabla prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yas 2☐No

25. Was case refarred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Othar (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐**Medical Examinar:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Yaer)
▶ MUSSA, MD	AJ-4147357	JUNE, 16, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Firas F. Mussa., The JOHNS HOPKINS HOSPITAL, 600 N WOLFE ST Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
JUN 19 2001	▶ S. Spaith

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24292

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Edward Mullen
2. Date of Death (Month, Day, Year): 07/28/2001
3. Time of Death: 7:15 PM
4a. Facility Name *(If not institution, give street and number)*: St. Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 028-22-3031
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04/26/1927
9. Birthplace *(State or Foreign Country)*: MASS.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 567 Woodbine Ave.
10f. Zip Code: 21204
10g. Citizen of What Country?: United States
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manufacturers Rep.
16b. Kind of Business/Industry: Manufacturing Cooper-McDonald
17. Father's Name *(First, Middle, Last)*: Edward Mathias Mullen
18. Mother's Name *(First, Middle, Maiden Surname)*: Lauretta Mullen
19a. Informant's Name/Relationship *(Type, Print)*: Beatrice L. Mullen/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 567 Woodbine Ave. Towson, Maryland 21204
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Svc Corp.
Date: 08/01/2001
20c. Location - City or Town, State: Towson, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOGENIC SHOCK

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: for Z Anett
29c. License number: D0050414
29d. Data signed *(Month, Day, Year)*: 7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 10755 Falls Road, Lutherville, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 1 - 2001
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24293

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kathleen B. Montgomery

2. Date of Death — Month: July; Day: 31; Year: 2001

3. Time of Death: 12:55 a.m.

4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-07-9302

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 15, 1918

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residance of Decedent

10a. Stete: MD

10b. County: Anne Arundel

10c. City, Town or Location: Gambrills

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 917 Waugh Chapel

10f. Zip Code: 21054

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Naver Merriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementery/Secondery (0-12): 9; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Name *(First, Middle, Last)*: Warren Edwards

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Lillian Schiflett

19a. Informent's Neme/Reletionship *(Type, Print)*: Brenda Meyers (Daughter)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 917 Waugh Chapel, Gambrills, MD 21054

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or othar piece)*: Metro Crematory

Dete: 07/31 2001

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Gabriel Gill

22. Name end Address of Fecility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the disaase, or complications thet caused the deeth. Do not enter the moda of dying, such es cardiac or raspiratory arrast, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in deeth)

a. End Stage Alzheimer's disease 5 year.

Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequance of):

d.

Pert II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Deeth *(Check only one)* — Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* — 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and mannar steted.

29b. Signeture and title of certifier: Paul S Rhodes MD

29c. Licanse number: D 22028

29d. Data signed *(Month, Day, Year)*: 7 31 01

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Paul S Rhodes MD 1667 Crofton Center Crofton 21114

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 1 - 2001

32. Registrer's Signatura: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24294

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
VERNON H MERSON JR	July 27 2001	12:06 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
265-42-7298	1☒M 2☐F	68 Yrs.			July 19 1933	MAryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Essex	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5 Brett Court	21221	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		Warehouse Foreman	HampedenMoving&Storage

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Vernon H Merson Sr.	Estella Poe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Merson / son	10810 Well Painter Dr. OwingsMills MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	OakLawn Cemetery	7/31/01	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Arteriosclerotic Coronary Artery disease

Due to (or es a consequence of):

c. End Stage Renal disease

Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0054428	7/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Michael Pipkin 9000 Franklin Square Drive Baltimore MD, 21237

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
AUG 1 - 2001	▶ D. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "natural', or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Merson, Vernon

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUSTIN Morel-Smith
2. Dete of Deeth: Month Jul Day 21 Year 2001
3. Time of Deeth: 12:45 PM
4e. Fecility Neme (If not institution, give street end number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Deeth: COLUMBIA
4c. County of Deeth: HOWARD

Funeral Director

5. Social Security Number: none
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthday) Yrs.: If Under 1 Year Months / Deys; If Under 24 Hrs. Hours 12 / Min.
8. Dete of Birth (Month, Day, Year): July 21, 2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 6 Shadynook Avenue
10f. Zip Code: 21229
10g. Citizen of Whet Country?: USA
11. Maritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 0; College (1-4or 5+) 0
16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Businass/Industry: none
17. Fether's Neme (First, Middle, Last): Bruce L. Smith
18. Mothar's Nama (First, Middla, Maiden Sumeme): Mary E. Morel
19a. Informent's Name/Reletionship (Type, Print): Howard County General Hospital
19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5755 Cedar Lane Columbia, MD 21044
20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [X] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place):
Dete:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name end Address of Fecility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failura. List only one ceuse on eech lina.

Approximete Interval Between Onsat and Deeth

Immediate Ceuse (Finel diseasa or condition resulting in deeth)
e. Respinatory Insufficiency
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted evants resulting in deeth) Lest
b. extreme prematurity
Due to (or as e consequence of):
c. Sepsis
Due to (or as e consequence of):
d.

Part II. **Other significent conditione** contributing to deeth but not resulting in tha underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Were eutopsy findings eveileble prior to complation of cause of daath? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Piece of Daath (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homlcide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Spacify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledga, daeth occurrad et the tima, data and place, end due to the ceuse(s) end menner as steted. 2 [ ] **Medical Examiner**: On tha basis of examination end/or investigetion, in my opinion, deeth occurred et the tima, data and place, and dua to tha cause(s) end menner statad.

29b. Signeture end title of certifier: Bharti Razdan MD
29c. License number: D47620
29d. Date signed (Month, Dey, Year): JUL 21, 2001

30. Name end eddrass of parson who completed cause of deeth (Item 23e) (Type, Print): Bharti Razdan 5755 Cedar Lane, Columbia, MD 21044

State Registrar

31. Date filed (Month, Dey, Yaar): AUG - 1 2001
32. Registrer's Signeture: Donna D Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elaine Mackey
2. Date of Death Month 7 Day 09 Year 2001
3. Time of Death: 1:45 A M
4a. Facility Name (If not institution, give street and number): Lorien-Frankford
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-34-3143
8. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-8-1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1509 Lester Morton Ct.
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Central Supplies Tech
18b. Kind of Business/Industry: Franklin Square Hospital

17. Father's Name (First, Middle, Last): John Pryor
18. Mother's Name (First, Middle, Maiden Surname): Rayella Carrington

19a. Informant's Name/Relationship (Type, Print): Sheila Mackey-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 Lester Morton Ct. 21205 Baltimore, MD

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Cemetery
Date: 8-2-2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shelley Miller
22. Name and Address of Facility: Miller's Metropolitan Chapel 1634 N. Broadway

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)
a. COPD (Chronic Obstructive Pulmonary Disease) — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as e consequence of):
b. HTN (Hypertension)
Due to (or as e consequence of):
c. CVA (Cerebral Vascular Accident)
Due to (or as e consequence of):
d.

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probebly 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause ot deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place ot Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth V. Loeb M.D.
29c. License number: D0051552
29d. Date signed (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth V. Loeb
21 Crossroads Drive Suite 330 Owings Mills, Maryland

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: G. Spencer

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma Narer

2. Date of Death (Month, Day, Year): July 26 2001

3. Time of Death: 10 PM

4a. Facility Name (If not institution, give street and number): Lorien Nursing & Convalescent Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-09-1797

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/31/1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1000 Grove Hill Rd.

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Geckle

18. Mother's Name (First, Middle, Maiden Surname): Anna Long

19a. Informant's Name/Relationship (Type, Print): John William Narer, Sr./husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Grove Hill Rd. Baltimore, Maryland 21227

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Cremation

Date: 7/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jan D Ambrose

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 2 Days

Due to (or as a consequenca of):

b. Chronic Obstructive Pulmonary Disease — 20 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A Eder

29c. License number: D38280

29d. Date signed (Month, Day, Year): July 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Eder 2/ Conroad, Drive, #333 Owings Mills MD 21117

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24298

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Thomas Neuhauser, Sr.
2. Date of Death Month Day Year: July 27 2001
3. Time of Death: 4:20 PM
4a. Facility Name (If not institution, give street and number): 60 Rocky Wood Lane
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-12-3367
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 7 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 60 Rocky Wood Lane
10f. Zip Code: 21220
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): foreman
18b. Kind of Business/Industry: CONSTRUCTION
17. Father's Name (First, Middle, Last): Samuel Neuhauser
18. Mother's Name (First, Middle, Maiden Surname): Josephine Ayres
19a. Informant's Name/Relationship (Type, Print): Samuel Neuhauser
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4236 Parleigh Rd. Baltimore, Md 21236
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gard. Date: July 31 2001
20c. Location - City or Town, State: Bel Air Maryland
21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Amended - Physician
29c. License number: D39758
29d. Date signed (Month, Day, Year): 7-30-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin Schendel MD 9101 Franklin Sq. Drive, Suite 321, Balto, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Neus
2. Date of Death (Month, Day, Year): 07/29/2001
3. Time of Death: 12:29 AM

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-26-2920
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07/14/1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 1901 Northleigh Road
10f. Zip Code: 21093
10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Station Owner
16b. Kind of Business/Industry: Exxon/Petroleum

17. Father's Name (First, Middle, Last): Paul J. Neus
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Coan

19a. Informant's Name/Relationship (Type, Print): Mr. Peter Neus/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1901 Northleigh Road Timonium, Maryland 21093

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp
Date: 08/31/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D42410
29d. Date signed (Month, Day, Year): 7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Meltzer 12221 Tullamore Rd Timonium Md 21093

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Winifred Bernice Ordner
2. Date of Death (Month, Day, Year): 07 27 2001
3. Time of Death: 0655
4a. Facility Name (If not institution, give street and number): (Patient's home) 420 VINE ST
4b. City, Town, or Location of Death: Westernport
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212 240339
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/09/1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Westernport
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 420 Vine Street
10f. Zip Code: 21562
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Walter Enick Blubaugh
18. Mother's Name (First, Middle, Maiden Surname): Bridget Mills

19a. Informant's Name/Relationship (Type, Print): Charles Sultzer/half brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3083 Chestnut Grove Road Sawnston, MD 21561

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cancer of left Kidney — 1yr 9mo
Due to (or as a consequence of):
b. Anemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: Gary L. Wagoner MD
29c. License number: D22181
29d. Date signed (Month, Day, Year): July 27, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR GARY L. WAGONER, 925 BISHOP WALSH DR, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24301

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

preston, emmart

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emmart H. Preston
2. Date of Death: Month July Day 29 Year 2001
3. Time of Death: 1910 M
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-18-3110
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 3, 1923
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11604 Terrytown Drive
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Purchasing
16b. Kind of Business/Industry: Electric

17. Father's Name (First, Middle, Last): Howard Preston
18. Mother's Name (First, Middle, Maiden Surname): Irene Emmart

19a. Informant's Name/Relationship (Type, Print): William P. Preston Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 Barnes Avenue, Westminster, MD 21157

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Baltimore National
Date: Aug. 2,2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Frank B Eline
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. pneumonitis
Approximate Interval Between Onset and Death: 3 Days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Wes decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
lung cancer
Respiratory failure

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24e. Was en autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: S. Raguraj MD
29c. License number: D 53 720
29d. Date signed (Month, Day, Year): 08/01/01 Aug-01-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Raguraj, 2112 Belair Rd #1, Fallston, MD 21047

State Registrar

31. Date filed (Month, Day, Year): JUL 31 2001
32. Registrar's Signature: Joyce P Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #30 PER DVR G798 8/08/01

Reg. No. 2001 24302

Reed, William 09/03/1931

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
WILLIAM CURTIS REED	7 / 30 / 01	0004 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Dorchester General Hospital	Cambridge	Dorchester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
193-24-4766	1 [X] M 2 [ ] F	69 Yrs.			Sept 3, 1931	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Dorchester	Cambridge	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
419 Linden Avenue	21613	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
unk 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '44-45	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	painter	unk

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Norman Reed	Marie Cisney

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William C. Reed (donor)	419 Linden Avenue Cambridge, MD 21613

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donetion 5 [ ] Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ronald S. Wade Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary Artery Disease	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Carcinoma

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 5 [ ] Pending investigation 2 [ ] Accident 6 [ ] Could not be determined 3 [ ] Suicide 4 [ ] Homicide		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D47232	7/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MARY SPENCER DESHIELDS DORCHESTER GENERAL HOSPITAL CAMBRIDGE MARYLAND 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 1 2001	▶ Geneva D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#30

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Rogers
2. Date of Death (Month, Day, Year): July 26, 2001
3. Time of Death: 4:15P M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-20-5644
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 21, 1922
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3000 McComas Ave.
10f. Zip Code: 20898
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pressor
16b. Kind of Business/Industry: Dry Cleaners

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Rether Rogers

19a. Informant's Name/Relationship (Type, Print): Laurita Rogers Patten - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 301: 418 Missouri Ave. N.W. Washington, D.C. 20011

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Quantico National
Date: 8-3-01
20c. Location - City or Town, State: Triangel, Va.

21. Signature of Funeral Servica Licensee: ▶ Robert B Baker Jr.
22. Name and Address of Facility: Shinn Funeral Service 2605 So. Shirlington Road Arlington, VA. 22206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Pneumonia — Approximate Interval: 1 day

Due to (or as a consequence of):
b. Myo Cardial Infarction

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):
c. Sepsis

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of deeth 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Keith E Damsker MD
29c. License number: D0057019
29d. Date signed (Month, Day, Year): July 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Keith Damsker 2309 Shorefield Road Wheaton, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: ▶ Bernice B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean P Reitz
2. Date of Death (Month, Day, Year): July 30th 2001
3. Time of Death: 12:10pm
4a. Facility Name (If not institution, give street and number): Copper Ridge
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-22-3223
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March10,1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13005 Jerome Jay Drive
10f. Zip Code: 21030
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Billing Clerk
16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Robert A. Reitz / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13005 Jerome Jay Drive; Cockeysville, MD 21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Hilltop Service Corp — Date: 7/31/01
20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: ▶ Peter V. Amy
22. Name and Address of Facility: Ruck Towson Funeral Home Inc. 1050 York Road Towson, MD 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Congestive Heart Failure — weeks
Due to (or as a consequence of):
b. Chronic obstructive pulmonary disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia of the Alzheimer's Type

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ernestine Wright, MD
29c. License number: D52740
29d. Date signed (Month, Day, Year): July 30th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ernestine Wright, Copper Ridge 710 Obrecht Road, Sykesville, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JULIA STILLEY

2. Date of Death: Month JULY Day 29TH Year 2001

3. Time of Death: 11:15 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE.

Funeral Director

5. Social Security Number: 239 48 3488

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 14, 1931

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 7419 MAURY ROAD

10f. Zip Code: 21244

10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH

College (1-4or 5+): UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING TECHNICIAN

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): JOSEPH STILLEY

18. Mother's Name (First, Middle, Maiden Surname): JULIA KEYS

19a. Informant's Name/Relationship (Type, Print): VERONA WEBB (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7419 MAURY ROAD BALTIMORE, MARYLAND 21244

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MURRAY FAMILY CEM.

Date: 8/4/2001

20c. Location - City or Town, State: BEAUFORT EDWARDS, N.C. Co.

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn

22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393
4517 PARK HEIGHTS AVENUE BALTO., MD.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

RR

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEVERE METABOLIC ACIDOSIS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. SYSTEMIC INFLAMMATORY RESPONSE SYNDROME

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE PANCREATITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D42723.

29d. Date signed (Month, Day, Year): JULY 29TH 2001

RR 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI HARISH - NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD. MD 21133.

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDITH AUGUSTA MORGAN SHORTER

2. Date of Death (Month, Day, Year): July 26, 2001

3. Time of Death: 11:11 PM

4a. Facility Name (If not institution, give street and number): STELLA MARIS AT MERCY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-20-2352

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-17-1923

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10a. Street and Number: 319 N. MONASTERY AVENUE

10f. Zip Code: 21229

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 TH GRADE

College (1-4or 5+): 3 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS EXAMINER

16b. Kind of Business/Industry: SOC. SEC. ADMIN.

17. Father's Name (First, Middle, Last): CLARENCE MORGAN

18. Mother's Name (First, Middle, Maiden Surname): GEORGIA THORNTON

19e. Informant's Name/Relationship (Type, Print): BRENDA MAPLE / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 CLEMATIS CT., OWINGS MILLS, MD. 21117

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CRESTLAWN CEMETERY

Date: 8-1-01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC OVARIAN CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

High Blood Pressure

Atrial fibrillation

Decubitus Ulcer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D0035074

29d. Date signed (Month, Day, Year): July 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WANDA CLEMMONS-SIMMONS 301 ST. PAUL PLACE, BALTO. MD. 21202

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 15

CHARLES SCHNEIDER
01-4017-003
RDC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 102201:ITEMS#23a,27,28a-f per ME G800 ss

Certificate of Death

Reg. No. 2001 24307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES H. SCHNEIDER JR
2. Data of Deeth — Month: JULY Day: 17 Year: 2001
3. Time of Death: 16:15 PM
4e Facility Name (If not institution, giva street and number): FRANKLIN SQUARE HOSPILAL
4b. City, Town, or Location of Death: ESSEX
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: unk
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Aug 17, 1959
9. Birthplace (Stata or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Steta: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 9906 Berliner Place
10f. Zip Code: 21221
10g. Citizen of Whet Country?: USA

11. Maritat Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): unk
Collega (1-4or 5+): unk
16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): Charles H. Schneider Sr
18. Mother's Neme (First, Middla, Maiden Surneme): unk

19e. Informent's Name/Relationship (Type, Print): Elizabeth Schneider/daughter
19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): unk

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removet from Stete 4☐ Donation 5☒ Other (Specify): in state
20b. Place of Disposition (Neme of cemetery, cremetory or othar piece)
Dete
20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name end Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused tha death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart faitura. List only one cause on eech line.
Approximete Intervet Between Onset and Deeth

Immediate Cause (Finet diseasa or condition resulting in death)
a. NARCOTIC INTOXICATION WITH COMPLICATIONS
Due to (or es e consequance of):
b.
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☒ Yas 2☐ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☒ Yes 2☐ No

25. Was case referred to medicat examiner? 1☒ Yes 2☐ No
26. Plece of Deeth (Check only ona): Hospital: 1☒ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Dey Year) Found: 7-14-01
28b. Time of Injury Found: 11:45a M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street end Number or Rurel Route Number, City or Town, State): 9906 Berliner Place, #H, Essex, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, end due to the cause(s) and mannar es stated. 2☒ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, deta end place, snd dua to tha cause(s) end manner steted.
29b. Signature and title of certifier: Theodore M. King MD
29c. Licensa number: OCME
29d. Date signed (Month, Dey, Yeer): JULY 18 2001
30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001
32. Registrer's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Sanders

2. Date of Death (Month, Day, Year): July 30, 2001

3. Time of Death: 3:00am

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice @ Towson

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-56-6053

6. Sex: 1☐ M 2☐ F (XX)

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 03-10-33

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No (XX)

10e. Street and Number: 11 West 20th Street

10f. Zip Code: 21218

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No (XX) If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No (X) Specify:

14. Raca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grada completed)

Elementary/Secondary (0-12): 9th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Trucking Company

17. Father's Nama (First, Middla, Last): James Salley, Sr.

18. Mother's Name (First, Middle, Maiden Surnama): Louise Stalling

19a. Informant's Name/Relationship (Type, Print): James Salley, Jr.

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 85374: 15941 W. LaPaloma Drive Sun City, Surpise

20a. Method of Disposition: 1☒ Burial (X) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): Mt. Calvary Cemetery

Date: 08-02-01

20c. Location - City or Town, State: Ann Arundel Co, MD

21. Signature of Funaral Sarvice Licensae: [signature]

22. Nama and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Liver Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown (X)

24a. Was an autopsy performed? 1☐ Yes 2☒ No (X)

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No (X)

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) Hospice (X)

27. Manner of Death: 1☒ Natural (X) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et tha time, date and place, and dua to the cause(s) end menner as stated. (X) 2☐ **Medical Examiner:** On the basis of examination end/or investigation, In my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. Licansa number: D43325

29d. Data signed (Month, Day, Year): 7/31/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature: [signature] Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

July 30, 2001 3:11 a.m.
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Sanders, James
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #20b PER FH G798 8/08/01 JH

Certificate of Death

Reg. No. 2001 24309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Trent Linwood Seawell
2. Date of Death: Month July, Day 26, Year 2001
3. Time of Death: 12:30 PM
4a. Facility Name (If not institution, give street and number): Mariner Health of Forest Hill
4b. City, Town, or Location of Death: Forest Hill
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-28-9067
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov. 14 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2321 High Point Road
10f. Zip Code: 21050
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Law

17. Father's Name (First, Middle, Last): Ernest Linwood Seawell
18. Mother's Name (First, Middle, Maiden Surname): Audrey Dunlap

19a. Informant's Name/Relationship (Type, Print): Delores Seawell / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2321 High Point Road Forest Hill MD 21050

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 7/30/01
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 1 day
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure.
Right Bronchial Mass

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: DO, FAAP
29c. License number: H39022
29d. Date signed (Month, Day, Year): July 27 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROGER Lonesti, DO 1308 Business Center Way Edgewood MD

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: Penny B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #20b PER FH G798 8/08/01

Reg. No: 2001 24310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JOSEPH WAYNE SHORT	JULY 28 2001	2:45a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
38 Francis Green Circle	Essex	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-07-0996	1☒M 2☐F	79 Yrs.			June 19 1922	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Essex	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13 Marie Ave.	21221	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Setup MAn Machines	Western Elictric

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Joseph George Short	Lillian Magaha

19a. Informant's Neme/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Beverly Sims / daughter	38 Francis Green Circle Baltimore MD. 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1☐Burial 2☒Cremation 3☐Removet from State 4☐Donation 5☐Other (Specify)	Bayview Crematory	8/01/01	Balitmore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	ConnellyFuneralHome of Essex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as e consequence of): ASCVD

c. Due to (or es a consequence of): HTN

d. Due to (or as e consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PVD

CVA

23e. Did tobacco use contribute to the cause of deeth? 1☑Yes 2☐No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Piece of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) Daughter's home

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Gabriel Mostyn Jam MD	D-48025	7-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SO HAIL MR & ARNI, MD 1224 CHESAPEAKE AVE BALTO, MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	▶ Bernice G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
YOUNG	THEODORE	SIMS	JULY 29 2001	unknown M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
919 ASHBRIDGE DRIVE	ESSEX	BALTIMORE CO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-32-2333	1 ☒ M 2 ☐ F	80 Yrs.			JUNE 27 1921	SOUTH CAROLINA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	BALTIMORE CO	ESSEX	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
919 ASHBRIDGE DRIVE	21221	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indien, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5th grade		STEEL WORKER	BETH STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
BURL SIMS	EMMA BROWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Ruby Sims/Wife	1101 Middleway Rd., Apt 3D, Baltimore, Maryland 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	KING MEMORIAL PARK	08-3-01	BALTIMORE, MARYALND

21. Signature of Funeral Service Licensee: Wade V. Brell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Esophageal Cancer — Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or es e consequence of):
c. — Due to (or as e consequence of):
d.

1yea-

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

28. Place of Deeth (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end menner es stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
MD	D33897	7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Vissing, MD 3509 Eastern Ave Baltimore MD 21224

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
AUG 1 - 2001	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24312

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Terrance Tyler
2. Date of Death (Month, Day, Year): July 28 2001
3. Time of Death: 12:35AM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-50-1600
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 14, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore.
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3010 Weaver Ave.
10f. Zip Code: 21214
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, Whita, etc. Specify: White.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): Joseph Donald Tyler.
18. Mother's Name (First, Middle, Maiden Surname): Pearl Thompson.

19a. Informant's Name/Relationship (Type, Print): Mary Tyler Watts
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 Smithy Ct., Baltimore, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL Chapel Bel Air, MD
Date: 7/31/01
20c. Location - City or Town, State: Forest Hill, MD

21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name end Address of Facility: EVANS FUNERAL CHAPEL 8800 HARFORD RD Baltimore, MD 21234

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications thet causad tha death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. — Approximate Intervel Between Onset end Death

Immediate Cause (Final disaesa or condition resulting in deeth): a. Bladder Cancer
Due to (or es a consequence of):
Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other elgnificant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contributa to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No
24b. Were eutopsy tindings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homlcide 5 [ ] Pending invastigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or invastigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 7/31/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Data filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

July 28, 2001 12:35 a.m.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Joseph Terry Tyler
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Preston Tull	July 28, 2001	10:22 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
243-22-0942	1☒ M 2☐ F	75 Yrs.			March 07, 1926	New Church, Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Florida	Duval County	Jacksonville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14217 Saybrook Falls Court	32224-5844	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean Conflict	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	n/a	Insurance Examiner	State of Maryland/Insurance

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Ewell Tull, Sr.	Fannie Hazel Allisworth

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Patricia May(nee O'Hara)Tull(Wife)	14217 Saybrook Falls Court Jacksonville,Florida 32224-5844

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Corporation	7/30/2001	Towson, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Maryland 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. esophageal cancer	7 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
N. Anthony Riley, MD	D25205	July 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 7530 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 1 - 2001	Donna D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SYLVAN TUERK
2. Date of Death (Month, Day, Year): JULY 29 2001
3. Time of Death: 1PM
4a. Facility Name (If not institution, give street and number): STELLA MARIS
4b. City, Town, or Location of Death: TIMONIUM
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-03-0327
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 13 1918
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6928 REISTERSTOWN ROAD
10f. Zip Code: 21215
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN
16b. Kind of Business/Industry: MEN'S CLOTHING

17. Father's Name (First, Middle, Last): MICHAEL TUERK
18. Mother's Name (First, Middle, Maiden Surname): FANNIE SIMON

19a. Informant's Name/Relationship (Type, Print): MS. MICHELE TUERK/ DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3023 KATEWOOD COURT BALTIMORE, MD. 21209

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FRIEDEL MARYLAND LODGE
Date: 7/31/01
20c. Location - City or Town, State: ROSEDALE, MD.

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 7/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood 2300 Dulaney Valley Rd. Timonium, MD 21093

State Registrar

31. Dete filed (Month, Dey, Year): AUG 1 - 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

July 29, 2001 1PM

Tuerk, SYLVAN

003

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Calvin Allen Vaughan

2. Date of Death: Month JULY; Day 26; Year 2001

3. Time of Death: 9:20 PM

4e. Facility Name (If not institution, give street and number): VA Medical Center, Fort Howard Md 21052

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 231 40 8063

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): 10 21 35

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 9860 Sapelo Road

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): Master

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Correction Officer

16b. Kind of Business/Industry: State of Correction

17. Father's Name (First, Middle, Last): Henry Vaughan

18. Mother's Name (First, Middle, Maiden Surname): Mataline Wood

19a. Informant's Name/Relationship (Type, Print): Calvin M. Vaughan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9860 Sapelo Road Baltimore, Maryland 21220

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA Cem.

Date: 08-02-01

20c. Location - City or Town, State: Owings Mills, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WM.C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Esophageal Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D0015698

29d. Date signed (Month, Day, Year): July 27, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Marcos Galicia MD 9600 NORTH POINT ROAD, FORT HOWARD MD 21052

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Vaughan, Calvin

54

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
DORIS J. VASEL	July 31 2001	1:00P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2820 Still Leaf Lane	Ellicott City	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
177 22 7899	1☐M 2☒F	72 Yrs.			June 23, 1929	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Ellicott City	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2820 Still Leaf Lane	21042	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alvin F. Bush	Ethel A. Lester

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Johanna Minner/Daughter	2820 Still Leaf Lane Ellicott City, MD 21042

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Union & West End Cem.	8-3-2001	Allentown, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Shawn A Collins - with M01044	Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Colon Cancer with metastasis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J Moody MD	D0055296	8/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. S. Moody 7061 Deepage Drive Columbia MD 21045

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 1 2001	▶ Denise D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24317

Yukov, Michael

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL CHARLES VUKOV
2. Date of Death (Month, Day, Year): July 23, 2001
3. Time of Death: 3:30 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-30-6658
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 11, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 8-F Alder Drive
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): driver
16b. Kind of Business/Industry: tractor trailer

17. Father's Name (First, Middle, Last): Joseph Michael Vukov
18. Mother's Name (First, Middle, Maiden Surname): Julia Doris Zukaitis

19a. Informant's Name/Relationship (Type, Print): Linda Mullineaux/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1122 Macadoo Avenue Baltimore, MD 21207

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Status Epilepticus	5days
Due to (or as a consequence of):	b. Cerebrovascular Accident	5days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hypertension	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart A. Willes, M.D.
29c. License number: D36663
29d. Date signed (Month, Day, Year): 07123101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stuart Willes 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): AUG 0 1 2001
32. Registrar's Signature: Donna D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

LARRY A WHITE SR
01-3901-510
RDC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24318

UNPENDED 040202:ITEMS#23a,27,28a-f per ME G806 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LARRY A. WHITE SR

2. Date of Death: Month JULY; Day 14; Year 2001

3. Time of Death: 5:41 AM

4e. Facility Name (If not institution, give street and number): 627 SOUTH PACA STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: unk

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): Mar 19, 1955

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 627 S. Paca Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: unk
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No unk
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Penn Street Baltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day, Year) Found: 7-14-02

28b. Time of Injury Found at: 5:30a M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 627 S. Paca St., Baltimore, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Snyder MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): JULY 14 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARJORIE P. SNYDER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CAROL WEINBERG
2. Date of Death: Month JULY Day 30 Year 2001
3. Time of Death: 12:25 AM
4a. Facility Name (If not institution, give street and number): HOSPICE OF BALTIMORE-GILCHRIST CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 073-38-0691
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 29 1947
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10e. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: COCKEYSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14 WARREN LODGE COURT #2-A
10f. Zip Code: 21030
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EDUCATOR
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): STANLEY WEINBERG
18. Mother's Name (First, Middle, Maiden Surname): ALICE FIELD

19a. Informant's Name/Relationship (Type, Print): MR. STUART WEINBERG/ BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 SECOND AVE. MERRICK, NEW YORK 11566

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. LEBANON
Date: 7/31/01
20c. Location - City or Town, State: GLENDALE, NY

21. Signature of Funeral Service Licensee: ▶ Edward C. Rusnak
22. Name and Address of Facility: SOL LEVINSON & BROS. INC 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic adenocarcinoma of

Due to (or as a consequence of): the intestine — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: ▶ for D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

CAROL 12:25AM 7.30.01 WEINBERG, 05-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Henry Wilson, Jr.
2. Date of Death Month: 7 Day: 23 Year: 01
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): 1041 Skyview Drive
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 254-56-4886
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/30/40
9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1041 Skyview Drive
10f. Zip Code: 21401
10g. Citizen of What Country? United State of America

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): manager
18b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): John Henry Wilson
18. Mother's Name (First, Middle, Maiden Surname): Ruby Mack

19a. Informant's Name/Relationship (Type, Print): Sheila Wilson/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1041 Skyview Dr. Annapolis, MD 21401

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville
Date: 8/1/01
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel 1922 Forest Dr. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CHOLANGIOCARCINOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen L. Kuhn MD
29c. License number: D0021336
29d. Date signed (Month, Day, Year): 7/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALBIN KUHN II, MD 6028 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Williams
2. Data of Death Month: July Day: 27 Yaar: 2001
3. Tima of Daath: 1945 M
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview
4b. City, Town, or Location of Daath: Baltemore
4c. County of Daath: NA

Funeral Director

5. Social Security Number: 223-50-0608
6. Sex: 1☐M 2☒F
7. Aga (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): OCT 2 1935
9. Birthplece (State or Foreign Country): NA

Usual Residance of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE, MD
10d. Insida City Limits: 1☒Yes 2☐No
10e. Street and Number: 3214 EASTERN AUE
10f. Zip Code: 21224
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☐No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yas 2☒No Specify:
14. Race - Amarican Indian, Black, White, etc. Spacify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): LINEN SERVICE
16b. Kind of Business/Industry: RESTURANT

17. Father's Nama (First, Middle, Last): OVILER L ROSS
18. Mother's Nama (First, Middla, Maidan Surname): EVELYN PLOTT

19a. Informant's Name/Relationship (Type, Print): KAREN BURKE
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3451 DUNHAVEN RD BALTO, MD 21222

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cematary, crematory or other place): GLEN HAVEN CEM
Data: 8/1/2001
20c. Location - City or Town, Stata: A, A, CO. MD

21. Signature of Funeral Service Licensee: ▶ Paul Stella
22. Nama and Addrass of Facility: HARTLEY MILLER FUNERAL HOME, CHTD 7527 HARFORD RD. BALTO, MD 21234

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line.

Approximata Intarval Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION — 30 MIN.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
Dua to (or as a consequence of):
b. UNCONTROLABLE EXSANGUINATION — 15 MIN.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yas, outcoma of pragnancy: 1☐Live birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to daath but not resulting in the undarlying ceusa givan in Part I.

23e. Did tobacco use contnbuta to tha causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed? 1☐Yas 2☒No
24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Placa of Daath (Chack only ona): Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA; Othar: 4☐Nursing Homa 5☐Residanca 6☐Other (Specify)
27. Manner of Death: 1☒Naturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined
28a. Date of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and dua to the cause(s) and manner as stated. 2☐Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha ceusa(s) and mannar stated.

29b. Signature and title of certifier: ▶
29c. Licansa number: 04934
29d. Date signad (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): JAY G. SHAKE MD 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

State Registrar

31. Data filed (Month, Day, Yaar): AUG 1 - 2001
32. Registrar's Signatura: ▶ Jay G. Shake

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24322

AMENDED ITEMS# 27,29a per phys G798 ss

Ziegler, Hubert

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): HUBERT A. ZIEGLER

2. Date of Death: Month JULY 18 Day 2001 Year — 3. Time of Death: 11:15 AM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

5. Social Security Number: 220-09-5530

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 30, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 23 Dunkirk Road

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): +5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mechanical engineer

16b. Kind of Business/Industry: Black & Decker

17. Father's Name (First, Middle, Last): Arthur Ziegler

18. Mother's Name (First, Middle, Maiden Surname): Viola Ferguson

19a. Informant's Name/Relationship (Type, Print): Anna Ziegler/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 Dunkirk Road Baltimore, MD 21212

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio respiratory arrest

Due to (or as a consequence of):

b. generalized sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. gangrene of the small bowel and colon

Due to (or as a consequence of):

d. atrial fibrillation - embolization

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

old age

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: 17944

29d. Date signed (Month, Day, Year): 7-19-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): S. SHAFIK 6569 N Charles street #605 Towson 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature: Geneva D Sparks

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Jean Zaenglein
2. Date of Death: Month July Day 30 Year 2001
3. Time of Death: 12:25PM
4a. Facility Name (If not institution, give street and number): University 1 Condominium
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 055-30-2350
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 11 1932
9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: University 1 Condominium
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) / College (1-4or 5+): +2
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Medical Secretary
16b. Kind of Business/Industry: Health Care
17. Fether's Name (First, Middle, Lest): Kelsie Hamilton Skinner
18. Mother's Name (First, Middle, Maiden Sumame): Bessie Evelyn Cecil
19a. Informant's Name/Relationship (Type, Print): Mary D. Skinner, M.D./ Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 14 Palmer Green Baltimore, Md. 21210
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cramatory or other place): Hilltop Service Co.
Date: 8-2-01
20c. Location - City or Town, State: Towson, Md.
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. Congestive Heart failure
Due to (or as a consequence of):
b. Atrial Fibrillation
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or es e consequence of):
c. Rheumatic Heart Disease.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D17803
29d. Date signed (Month, Day, Year): 7-31-01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Warren Israel MD 6569 North Charles st #600 Baltimore MD. 21204

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 1 - 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24324

Zimmerman, Louis
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis R. Zimmerman Jr.

2. Date of Death (Month, Day, Year): July 30, 2001

3. Time of Death: 6:50 P. M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-40-2259

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 30 1942

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1 Brett Court

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Chesapeake Corp.

17. Father's Name (First, Middle, Last): Louis R. Zimmerman Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Catherine Hutson

19a. Informant's Name/Relationship (Type, Print): Carolyn Zimmerman / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Brett Court Apt.114 Baltimore MD 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial

Date: 8/3/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Osteomyelitis

Due to (or as a consequence of):

c. Non Healing Wounds

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Transplant, Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D53462

29d. Date signed (Month, Day, Year): 7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jude C. Muneses, 9000 Franklin Square Drive, Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): AUG 1 - 2001

32. Registrar's Signature: Bernice D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar — Amend Item#18 Per FH 7-19-2001; Amend Item #1 Per Phy. 7-19-2001

Certificate of Death HCHD LM

Reg. No. 2001 24325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~HAROLD R. BURK~~ Harold Ross Burk Sr.

2. Date of Death (Month, Day, Year): July 17 2001

3. Time of Death: 1344 M

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-32-0152

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 2, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1216 Sharon Acres Road

10f. Zip Code: 21050

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Dairy

17. Father's Name (First, Middle, Last): August Oscar Burk

18. Mother's Name (First, Middle, Maiden Surname): ~~Bessie (UNK) Albright~~ Mary Rosella Albright

19a. Informant's Name/Relationship (Type, Print): Blanche E. Burk/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1216 Sharon Acres Road, Forest Hill, MD 21050

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 7-23-01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: Steven A Mengel

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCT — 2-3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE — Years

Due to (or as a consequence of):

d. ATHEROSCLEROSIS. — Years.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- STAPHYLOCOCCUS SEPTICEMIA.
- END STAGE RENAL DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Luis F. Gomez MD

29c. License number: D31960

29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUIS F. GOMEZ Upper Chesapeake Medical Center

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001

32. Registrar's Signature: Bonnie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BURK, HAROLD R

6

01-3939-015

jhm AMEND ITEM#23a per ME G800 101001 ss

ROBERT AMENDED ITEM#28a per ME G798 082901 SS

BLANKENSHIP UNPENDED 080801:ITEMS#23a,27,28a-f per ME G798 ss

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24326

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Howard Blankenship

2. Date of Death Month Day Yaer: JULY 16, 2001

3. Time of Death: 09:15 AM

4a Facility Name *(If not institution, give street and number)*: 103 MILLER STREET

4b. City, Town, or Location of Death: ELKTON

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 218-70-3801

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 43 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: February 24, 1958

9. Birthplace *(Stata or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 103 Miller Street

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decadent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grada completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Body & Paint Shop

16b. Kind of Business/Industry: General Motors

17. Fethar's Nema *(First, Middle, Last)*: Charles Evans Blankenship, Sr.

18. Mothar's Neme *(First, Middle, Maiden Surneme)*: Betty Simpers

19a. Informent's Neme/Relationship *(Type, Print)*: Betty S. Blankenship / Mother

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 255 Woods Way, Cecil Woods, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: North East Methodist Cemetery

Date: July 21, 2001

20c. Location - City or Town, Stata: North East, Maryland

21. Signature of Funaral Service Licensee: Robert O. Crouch

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. STREPTOCOCCAL PNEUMONIAE MENINGITIS AS A COMPLICATION OF REMOTE ~~GUNSHOT WOUNDS TO THE HEAD~~ INTRA-ORAL GUNSHOT WOUNDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☒ Yes 2☐ No

25. Was case referred to medicet examiner? 1☒ Yes 2☐ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☒ Other *(Specify)* SCENE

27. Menner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey, Year)*: ~~6-8-01~~ 6/8/97

28b. Time of Injury: 5:35p M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: subject shot himself and developed complications

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: residence

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*: 103 Miller St., Elkton, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. Licansa number: OCME

29d. Date signed *(Month, Dey, Year)*: JULY 17, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): MARY C. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: JUL 10 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Charles Bickling, Jr.

2. Date of Death (Month, Day, Year): July 22, 2001

3. Time of Death: 04:45 AM

4a. Facility Name (If not institution, give street and number): 199 Shady Beach Road

4b. City, Town, or Location of Death: North East

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 186-16-3772

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 12, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 199 Shady Beach Road

10f. Zip Code: 21901

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Produce Manager

16b. Kind of Business/Industry: Retail Grocer

17. Father's Name (First, Middle, Last): Ralph Charles Bickling, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Reba Todd

19a. Informant's Name/Relationship (Type, Print): Fran Bickling / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 199 Shady Beach Road, North East, Maryland 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gracelawn Cemetery

Date: July 25, 2001

20c. Location - City or Town, State: New Castle, Delaware

21. Signature of Funeral Service Licensee: Robert G. Crouch

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death) e. Bladder Cancer — 1 month

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Farkas, MD

29c. License number: D15314

29d. Date signed (Month, Day, Year): July 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUL 23 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-4091-027
mnmr
Brianna M. Bratton

UNPENDED 083001:ITEMS#23a,27 per ME G798 SS AMEND ITEM#15 per fh G798 SS 083001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Brianna Marlene Bratton

2. Date of Death: Month July, Day 20, Year 2001

3. Time of Death: 446 am

4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-59-0312

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months 6, Days 12

If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Jan. 8, 2001

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Conowingo

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 396 East Red Hill Road

10f. Zip Code: 21918

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Never Worked

16b. Kind of Business/Industry: Never Worked

17. Father's Name (First, Middle, Last): Thomas Edward Bratton

18. Mother's Name (First, Middle, Maiden Surname): Penny Lee Keller

19a. Informant's Name/Relationship (Type, Print): Penny Lee Keller (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 396 East Red Hill Road, Conowingo, Maryland 21918

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): West Nottingham Cemetery

Date: 7/23/01

20c. Location - City or Town, State: Colora, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.

Due to (or as a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): July 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 23 2001

32. Registrer's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Yaar	3. Tima of Daath
Virginia	L.	Barnhart	July	17	2001	11:48 AM

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (Stata or Foreign Country)
217-10-4452	1☐M 2☒F	65 Yrs.			Jul 1, 1936	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Allegany	Cumberland	1☒Yas 2☐No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
901 Seton Drive	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, Whita, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yas 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		None	None

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Joseph Walter Barnhart	Elva L (Eckshaw)

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)
James Barnhart brother	135 N Mechanic St--803;Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Hillcrest Memorial Par	7/19/2001	Cumberland, MD

21. Signature of Funaral Service Licensee	22. Name and Addrass of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on aach lina.

Approximata Interval Betwaan Onset and Daath

Immediata Cause (Final disease or condition rasulting in death)	a. CONGESTIVE HEART FAILURE	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as a consequence of): b. ACUTE RENAL FAILURE	DAYS
	Due to (or as a consequance of): c.	
	Due to (or as a consequance of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Data of dalivary Month / Day / Year
1☐Yas 2☒No 9☐Unknown	1☐Live birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to daath but not rasulting in the undarlying cause givan in Part I.

23a. Did tobacco use contributa to tha cause of daath?	24a. Was an autopsy performed?	24b. Ware autopsy findings availabla prior to complation of causa of death?
1☐Yas 2☒No 3☐Probably 4☐Unknown	1☐Yas 2☒No	1☐Yas 2☐No

25. Was case rafarrad to medical examiner?	26. Placa of Daath (Chack only ona)	
1☐Yas 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidance 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined		M	1☐Yas 2☐No	

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)	28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Yaar)
▶ MD	D50931	July 17 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
VIRGINIA G. MAKRIDES, MD 912 SETON DRIVE CUMBERLAND, MD 21502

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
JUL 18 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24330

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Henry Bowden
2. Date of Death: Month July, Day 21, Year 2001
3. Time of Death: 10:30 AM
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-14-6058
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.
8. Date of Birth *(Month, Day, Year)*: Dec 5, 1922
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 831 Mt. Royal Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yes 2 X No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: CSX Transportatio
17. Father's Name *(First, Middle, Last)*: Charles Bowden
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth (Cook)
19a. Informant's Name/Relationship *(Type, Print)*: Ruth E. Painter sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 205 Pennsylvania Avenu;Cumberland MD 21502
20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rocky Gap Veterans Cem
Date: 7/24/2001
20c. Location - City or Town, State: Flintstone, MD
21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR INFARCTION — 24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Welik
29c. License number: D31875
29d. Date signed *(Month, Day, Year)*: JULY 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Welik M.D. 902 Seton Drive Cumberland MD 21502

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24331

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD ANDREWS BIEGEL
2. Date of Death Month / Day / Year: July 16 2001
3. Time of Death: 0708AM
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Easton, Md
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-30-9080
8. Sex: 1[X] M 2[ ] F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 19 1935
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1[X] Yes 2[ ] No
10e. Street and Number: 29624 TALLULAH LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1[X] Yes 2[ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1[ ] Yes 2[X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER
18b. Kind of Business/Industry: US POSTAL SERVICE

17. Father's Name *(First, Middle, Last)*: EDWARD BIEGEL
18. Mother's Name *(First, Middle, Maiden Surname)*: DORIS ANDREWS

19a. Informant's Name/Relationship *(Type, Print)*: MARY FLEETWOOD/PERSONAL REP.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29624 TALLULAH LANE, EASTON, MD 21601

20a. Method of Disposition: 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION
Date: CTR 7-21-01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ Joseph M. Ostrowski C.F.S.P.
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. VENTRICULAR TACHYCARDIA
Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last:
b. Due to (or es a consequenca of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset end Death: 10 MINUTES

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[X] No 9[ ] Unknown
23c. If yes, outcome of pregnancy: 1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other *(specify)* 9[ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of deeth? 1[ ] Yes 2[X] No 3[ ] Probebly 4[ ] Unknown

24a. Was en autopsy performed? 1[ ] Yes 2[X] No
24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

28. Place of Death *(Check only one)*: Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA; Other: 4[ ] Nursing Home 5[ ] Residence 8[ ] Other *(Specify)*

27. Manner of Death: 1[X] Neturel 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1[ ] Yes 2[ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1[X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) end manner as steted. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ C. Rw Bain M.D
29c. License number: D0000250
29d. Date signed *(Month, Dey, Year)*: 7/16/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CALLUM R. W. BAIN M.D. 609 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Dey, Year)*: JUL 18 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Edward Biegel

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a per phys G798 082001 SS
AMENDED 080101 ITEMS# 8 per fh G798 SS

Certificate of Death

Reg. No. 2001 24332

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rita Marie Brockmeyer
2. Date of Death Month/Day/Year: July 10, 2001
3. Time of Death: 6:25 pM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-14-3928
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 9, 1920
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 122 Arundel Beach Road
10f. Zip Code: 21146
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
18b. Kind of Business/Industry: Magazine

17. Father's Name (First, Middle, Last): Ambrose Vogt
18. Mother's Neme (First, Middle, Meiden Surneme): Claira Hamilton

19a. Informant's Name/Relationship (Type, Print): Gerald G. Brockmeyer, Jr/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 122 Arundel Beach Road, Severna Park, MD 21146

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Dentition 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Metro Crematory
Date: July 13, 2001
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: James E Barranco
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. ~~Septic Shock~~ SEPSIS — 7-24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2☐Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert T Peterson MD
29c. License number: D24804
29d. Date signed (Month, Day, Yeer): 7-10-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert T Peterson 600 Ridgely Ave Annapolis Md

State Registrar

31. Date filed (Month, Day, Year): JUL 12 2001
32. Registrar's Signature: Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

P.G.

[illegible] 1005 S 1 [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended 1., 7/24/01, LDB, Dor. Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24333

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Madge Cecelia Badger — Also known as: Maggie Cecelia Badger
2. Dete of Deeth: Month 7 Day 16 Yeer 01
3. Time of Deeth: 0627
4a. Facility Nema (If not institution, giva straet and numbar): 612 Bradley Ave.
4b. City, Town, or Location of Death: Cambridge
4c. County of Deeth: Dorchester

Funeral Director

5. Social Security Number: 214-34-5411
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 96 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 10/17/1904
9. Birthplece (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 612 Bradley Avenue
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armad Forces? 1☐ Yes 2☒ No — If Yes, Give Yaar or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: Black

15. Decedent's Eddcetion (Specify only highest grade completed): Elementary/Secondary (0-12): 03 — College (1-4or 5+): None
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Work
16b. Kind of Business/Industry: Food Processing

17. Fethar's Neme (First, Middle, Last): William Henry Collins
18. Mother's Neme (First, Middle, Meiden Surneme): Rosie Savage

19a. Informent's Name/Relationship (Type, Print): Joan Badger Wilson/Granddaughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1303 Rainbow Avenue Cambridge, maryland 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Bethel Cemetery — Date: 8/21/200
20c. Locetion - City or Town, Stete: Cambridge, maryland

21. Signeture of Funeral Service Licensee: Mattie L. Boardley
22. Name end Address of Fecility: Boardley Funeral Home, 812 Hubbard Street Cambridge, maryland 21613

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Pert1. Enter the disaasa, or complications that causad the death. Do not antar tha moda of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line. — Approximata Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. ASCVD
Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☑ Yes 2☐ No
26. Piece of Deeth (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☑ **Medical Examiner**: On the besis of exemination end/or invastigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted.
29b. Signature and title of certifier: D.O. DME
29c. Licensa number: H50497
29d. Data signad (Month, Day, Year): 7/17/01

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Chris Snyder D.O. 106 Milford St. #201 Salisbury MD 21801

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM# 23a-line c per phys G797 ss 080101

Certificate of Death

Reg. No: 2001 24334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Thomas Baker	June 25, 2001	9:41 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-36-3959	1 X M 2 ☐ F	60 Yrs.			Oct. 11, 1940	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Walkersville	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8514 Fountain Rock Court	21793	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes X ☐ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Assembler	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William McKinley Baker	Louella Bruchey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Nancy I. Baker, wife	8514 Fountain Rock Court, Walkersville, Md. 21793

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Resthaven Memorial Gardens,	June 29, 2001	Frederick, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard E. Bray M00255	Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction ~~IV fibrillation~~ — 0

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease — 15 yrs

Due to (or as a consequence of):

c. V. FIBRILLATION

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ John Walker MD	D0030020	06-25-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
15 E. Frederick St, PO Box 310, Walkersville, Md 21793

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 29 2001	▶ Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FREDERICK

23a c

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24335

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Robert James Culotta	July 14, 2001	7:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3106 Birch Brook Lane	Abingdon	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-28-7057	1☐M 2☐F X	68 Yrs.			April 4, 1933	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Abingdon	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3106 Birch Brook Lane	21009	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1951-1953	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Bartender	Bar

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Culotta	Jessie Sweitzer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Daria Lee Culotta Wife	3106 Birch Brook Lane, Abingdon, Md. 21009

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☒Donetion 5☐Other (Specify)	Bel Air Memorial Gard	July 18, 2001	Bel Air Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air, MD 21014

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	1d
Due to (or as a consequence of): b.	Hypertension	5 yrs
Due to (or as a consequence of): c.	Chronic obstructive lung disease	10 yrs
Due to (or as a consequence of): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

1F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Dey / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) _____ 9☐Unknown	

Part ft. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was an eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end menner as steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
physician	D29769	7/16/2001

30. Name and address of person who completed cause of death (Item 30a) (Type, Print)

Marcelino D. Albuerne ons 516 N. Rolling Rd Bel Air 21228

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
JUL 18 2001	Brenda B Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1041

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joyce W. Cockerham
2. Date of Death (Month, Day, Year): July 19 2001
3. Time of Death: 1809 M
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-16-0705
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 13, 1929
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1881 Telegraph Road
10f. Zip Code: 21911
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
18b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Raymond H. West
18. Mother's Neme (First, Middle, Maiden Surname): Edith Fowler

19a. Informant's Name/Relationship (Type, Print): Carol Belote/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 325 Fell Road, Rising Sun, MD 21911

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ebenezer U. M. Cem.
Date: 7/22/2001
20c. Location - City or Town, State: Newark, Delaware

21. Signeture of Funeral Service Licensee ▶
22. Name and Address of Facility: R. T. Foard & Jones, Inc. 122 West Main Street, Newark, DE 19711

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or Heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — Approximate Interval Between Onset and Death: Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was en autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Sachdev MD
29c. License number: D23322
29d. Date signed (Month, Day, Year): 7.20.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. S. SACHDEV MD, 118 North St Suite 3B, Elkton MD 21921

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24337

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA M. CONNER

2. Date of Death: Month July, Dey 10, Yeer 2001

3. Time of Death: 12:55 PM

4a. Facility Name (If not institution, give street and number): 4100 Jacksonville Road

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 216-14-9132

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Nov. 17, 1924

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4100 Jacksonville Road

10f. Zip Code: 21817

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Quality Control Inspector

16b. Kind of Business/Industry: Paintbrush Manufacture

17. Father's Name (First, Middle, Last): Columbus Betts

18. Mother's Name (First, Middle, Maiden Surneme): Ida A. Elste

19a. Informent's Name/Relationship (Type, Print): Harlton J. Conner (Husband)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4100 Jacksonville Road - Crisfield, MD 21817

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Sunnyridge Memorial Park

Date: 7/13/01

20c. Location - City or Town, State: Crisfield, Maryland

21. Signature of Funerel Service Licensee: Mary Beth Bradshaw-Pruitt

Mary Beth Bradshaw-Pruitt

22. Name end Address of Fecility: Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturel", or items 23e or 28e-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death)

e. ALZHEIMERS DISEASE — YEARS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other eignificant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner steted.

29b. Signature end title of certifier: Marlan O. Barhan

29c. License number: 12764

29d. Date signed (Month, Dey, Yeer): July 12, 2001

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): M. D. Barhan, M.D. - 4384 Crisfield Highway - Crisfield, Maryland 21817

State Registrar

31. Dete filed (Month, Dey, Yeer): JUL 16 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JETTA J. CARMINE

2. Data of Death: Month July Day 10, Year 2001

3. Time of Death: 6:30 PM

4a. Facility Name (If not institution, give street and number): McCready Memorial Hospital

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 213-22-8213

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Aug. 11, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 308 W. Chesapeake Avenue

10f. Zip Code: 21817

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk

16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): William Sherman Dize

18. Mother's Name (First, Middle, Maiden Surname): Novella Davis

19a. Informant's Name/Relationship (Type, Print): Novella A. Bozman (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 N. First Street-Crisfield, Maryland 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crisfield Cemetery

Date: 7/13/01

20c. Location - City or Town, State: Crisfield, Maryland

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt

Mary Beth Bradshaw-Pruitt

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main Street - Crisfield, MD 21817

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0047637

29d. Date signed (Month, Day, Year): 7-10-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH INZERILLO M.D. - 201 Hall Highway - Crisfield, MD 21817

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24339

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES LUTHER CHANCE

2. Date of Death — Month: July Day: 12 Year: 2001

3. Time of Death: 11:30pm

4a. Facility Name *(If not institution, give street and number)*: Caroline Nursing Home & Rehabilitation Ctr

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 218-20-9454

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: OCT 6 1929

9. Birthplece *(Stata or Foraign Country)*: MD

Usual Rasidence of Decedent

10a. Stata: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1 ☒ Yas 2 ☐ No

10e. Street and Number: 17 S.E. DUKE ST

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Maritaf Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No — If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: PARTS MANAGER

16b. Kind of Businass/Industry: AUTO

17. Fathar's Nama *(First, Middla, Last)*: LESLIE R. CHANCE

18. Mothar's Nama *(First, Middla, Maiden Surnama)*: MILDRED E. SOULSBY

19a. Intormant's Name/Ralationship *(Type, Print)*: SHIRLEY F. CHANCE/WIFE

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 17 S.E. DUKE ST., EASTON, MD 21601

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetary, crematory or othar place)*: WOODLAWN MEMORIAL PARK

Data: 7-17-01

20c. Location - City or Town, Stata: EASTON, MD

21. Signature of Funaral Sarvice Licensee: ▶ M. E. Newnam III C.F.S.P.

22. Nama and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on aach line.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaese or condition resulting in death)

a. Alzheimers Dementia — years

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Ware autopsy tindings available prior to completion of cause ot deeth? 1 ☐ Yas 2 ☒ No

25. Was casa refarred to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place of Death *(Check only ona)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Othar *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending invastigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, tactory, office building, atc. *(Specify)*

28t. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and piece, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier: ▶ James Siles MD

29c. License number: D31376

29d. Data signed *(Month, Day, Year)*: 7-13-01

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): James Siles 920 Market St Denton MD 21629

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24340

Elsie Callahan

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELSIE MOORE CALLAHAN

2. Date of Death (Month, Day, Year): July 17, 2001

3. Time of Death: 0935 M

4a. Facility Name (If not institution, give street and number): Memorial Hospital at Easton

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-44-1728

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 16 1915

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE'S

10c. City, Town or Location: CENTREVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 609 CHURCH HILL RD

10f. Zip Code: 21617

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

18b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HARRY B. MOORE

18. Mother's Name (First, Middle, Maiden Surname): OLA DRAPER

19a. Informant's Name/Relationship (Type, Print): PHYLLIS SPIES/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 820 BRIDGETOWN RD, HENDERSON, MD 21640

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHESTERFIELD CEMETERY

Date: 7-20-01

20c. Location - City or Town, State: CENTREVILLE, MD

21. Signature of Funeral Service Licensee: JOHN R. MERCER CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN &NEWNAM FUNERAL HOME P.A. 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE Heart FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aortic Stenosis

Due to (or as a consequence of):

c. Atrial Fibrillation

Due to (or as a consequence of):

d. Coronary Artery Disease

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery (Month, Day, Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric R. Ciganek M.D.

29c. License number: D35043

29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC R. CIGANEK M.D. 2540 CENTREVILLE RD, CENTREVILLE, MD 21617

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001

32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alvis Norman Dumas
2. Date of Death: Month 07 Day 20 Year 01
3. Time of Death: 13:50
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 561-54-2819
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 31, 1921
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 645 Franklin Street
10f. Zip Code: 21903
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1940-60
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): Two Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Instructor
16b. Kind of Business/Industry: Bainbridge Naval Training Ctr. Port Deposit, Maryland

17. Father's Name (First, Middle, Last): William N. Dumas
18. Mother's Name (First, Middle, Maiden Surname): Mary Jewel Cockrell

19a. Informant's Neme/Relationship (Type, Print): Cynthia S. Dumas (daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda): 645 Franklin Street, Perryville, Maryland 21903

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Principio Cemetery
Date: 7/25/01
20c. Location - City or Town, Stete: Perryville, Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Sr.
22. Name and Address of Fecility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)
a. Septic Syndrome
Due to (or as a consequence of):
b. Pancytopenia
Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Multiple Myeloma
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contributs to the causs of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, and due to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D 0055722
29d. Date signed (Month, Day, Year): 07/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Seong Chin 319 South Union Avenue, Havre de Grace, MD 21078

State Registrar

31. Date filed (Month, Dey, Year): JUL 23 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1/A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pansie Mae Davis

2. Date of Death Month Day Year: July 20, 2001

3. Time of Death: 1:00 P. M

4a. Facility Name (If not institution, give street and number): Frostburg Village Nursing Care Ctr.

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-1250

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 18, 1906

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: LaVale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 516 A Street

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): UnKnown

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hostess & Cashier

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): James David Chaney

18. Mother's Name (First, Middle, Maiden Surname): Etta Lear Trueax

19a. Informant's Name/Relationship (Type, Print): Vernon Chaney / Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): HC 60, Box 62 - Levels WV 25431

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Frostburg Meml. Gdns.

Date: 07/22/2001

20c. Location - City or Town, State: Frostburg, MD

21. Signature of Funeral Service Licensee: Wendy D. Upchurch

22. Name and Address of Facility: Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT — Approximate Interval Between Onset and Death: 3 weeks

Due to (or as a consequence of):

b. CEREBRAL ARTERIOSCLEROTIC DISEASE — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Dementia, Parkinsonism

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Sidhu

29c. License number: D26907

29d. Date signed (Month, Day, Year): JULY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Sidhu, M.D 925 BISHOP WELSH RD - CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 23 2001

32. Registrar's Signature: Barbara B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT NATHAN DEAL

2. Data of Death Month Day Yaar: July 19, 2001

3. Tima of Death: 5:21 A. M

4a. Facility Name (If not institution, giva street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Deeth: Allegany

Funeral Director

5. Social Security Number: 217 14 4989

6. Sex: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): JULY 24,1921

9. Birthplace (Stata or Foraign Country): MARYLAND

Usual Residence of Decedent

10a. State: PA

10b. County: FAYETTE

10c. City, Town or Location: MARKLEYSBURG

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 5491 NATIONAL PIKE

10f. Zip Coda: 15459

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - American Indian, Black, Whita, atc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired): HEAVY EQUIPMENT OPERATOR

16b. Kind of Businass/Industry: CONSTRUCTION

17. Father's Nama (First, Middle, Last): ELMER DEAL/ WIFE

18. Mothar's Nama (First, Middla, Maiden Sumame): BERTHA DURST

19a. Informant's Name/Relationship (Type, Print): ELSIE DEAL

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 5491 NATIONAL PIKE, MARKLEYSBURG, PA 15459

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cematery, crematory or other place): ADDISON CEMETERY

Dete: 7/22/01

20c. Location - City or Town, Stata: ADDISON, PA 15411

21. Signature of Funeral Service Licensee

22. Name and Addrass of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on each lina.

Approximeta Intarvat Batwaen Onsat and Daath

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease — 5 years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of dalivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peripheral embolic disease

23e. Did tobecco usa contribute to tha cause of daath? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to compiation of cause of daath? 1 [ ] Yes 2 [X] No

25. Was case refarred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Daath (Chack only ona)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Othar: 4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: Robustiano J. Barrera, Jr.

29c. License number: D0014865

29d. Data signed (Month, Day, Year): July 22nd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 500 Memorial Avenue, Ste. 201 DR. Robustiano Barrera, Memorial Medical Building, Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 23 2001

32. Registrar's Signatura: Georgia D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ROBERT DEAL 217-14-4989

Amended #30, nl, 7/25/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24344

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Robert	Alan	Di Giacomo	July 21, 2001	2310 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-58-8214	1 X M 2 F	48 Yrs.			Feb 3, 1953	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Garrett	Friendsville	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
702 Norris Avenue Apt. 303	21531	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Motor Vehicle Adm

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Richard Di Giacomo	Nancy L Cohen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Melanie Parks sister	19279 Haugh Road; Stewartstown PA 17363

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Scarpelli Funeral Home	7/23/2001	Cresaptown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. HEPATORENAL SYNDROME	>3mon.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CIRRHOSIS OF LIVER	>3Yrs.
Due to (or as a consequence of):		
	c. ALCOHOL ABUSE +	>10Yrs.
Due to (or as a consequence of):		
	d. HEPATITIS C	>6Yrs.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCITES.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 X No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
S. C. Khanna	D54004	July 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHIVE C. KHANNA 625 KENT AVE. SO. CUMBERLAND, MD. 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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2 MD

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Mary	Jo	Devitt	July	22	2001	10:06 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
194-36-8585	1☐M 2☒F	54 Yrs.			Apr 16, 1947	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
532 Cumberland Street	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5+	nursing instructor	College

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dr. Edward McNicholas	Josephine (Nalazek)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert L. Devitt husband	532 Cumberland Street; Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Scarpelli Funeral Home	7/26/2001	Cresaptown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	24 Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. PNEUMONIA	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NEUTROPENIA 2° to CHEMOTHERAPY

(R) BREAST CANCER

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], MD	D5093	July 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIRGINIA C. MAGRUDER, MD 912 SETON DRIVE CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 24 2001	▶ [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Mattie	W.	Dulin	07	14	2001	2:40 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WM. HILL MANOR	EASTON	TALBOT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-62-0371	1☐ M 2☒ F	89 Yrs.			SEPT 25 1911	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	EASTON	☒ 1 Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29360 PRICE ST.	21601	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES L. WHITBY, SR.	ELIZABETH WOLFE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JACQUELYN D. HURLEY/DAUGHTER	29360 PRICE ST EASTON, MD 21601

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SPRING HILL CEMETERY	7-19-01	EASTON, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ M. E. Newnam III CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular accident	months
Due to (or as a consequence of):	b. Atherosclerosis, generalized	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Stokes Stokes syndrome with permanent cardiac pacemaker

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Michael Crowley MD	D25933	7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL D. CROWLEY 503 IDLEWILD AVE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HELEN ELIZABETH HEAPS ENFIELD	July 3 2001	1:50 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Brightview Assisted Living	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-70-7742	1☐ M 2☒ F	95 Yrs.			04/26/1906	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Kingsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11509 Cedar Lane	21087	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Winfield Heaps	Dorothy McLaughlin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lois E. Akehurst-Daughter	11509 Cedar Lane, Kingsville, MD 21087

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Highland Cemetery	7/6/01	Street, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Jeffrey P. Lovelidge	Harkins Funeral Home, Inc., Delta, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart Failure	yrs
Due to (or as a consequence of):	Mitral Stenosis	yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph A. Reinhardt	D0015673	7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A. Reinhardt, M.D. 2003 Rock Spring Road, Forest Hill, MD 21050

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
GEORGE NOLAN EDWARDS	July 18 2001	3:25pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shore Nursing & Rehabilitation	Denton	Caroline

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-16-9971	1☒ M 2☐ F	76 Yrs.			May 1 1925	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Kent	Millington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
347 Cypress St.	21651	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Yaar or Dates:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Bridge Tender	Maryland State Hwy Administration

17. Fathar's Nama (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surname)
Willard Burton Edwards	Anastasia Haley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Glada Edwards (wife)	P.O. Box 431 Millington, MD. 21651

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donatory 5☐ Other (Specify)	Massey Cemetery	7/22/01	Massey, MD.

21. Signatura of Funeral Service Licensee	22. Name and Address of Facility
M00510	Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SQUAMOUS CELL CARCINOMA	3-4 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D35284	7/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDROS ALLEN MD 219 S. Washington St Easton MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	[signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#12 Per FH 7-24-01 HCHD LM

Certificate of Death

Reg. No. 2001 24349

NAME KNOWN TO PHYSICIAN: FALLON, JOSEPH
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Elbert Fallon

2. Date of Death (Month, Day, Year): July 16 2001

3. Time of Death: 6:30 pm

4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System

4b. City, Town, or Location of Death: Perry Point

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-22-6935

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 25, 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 733 Revolution Street

10f. Zip Code: 21078

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1/14/48 to 3/19/48

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant

16b. Kind of Business/Industry: Hospital-VA

17. Father's Name (First, Middle, Last): Joseph Edward Fallon

18. Mother's Name (First, Middle, Maiden Surname): Stella Price

19a. Informant's Name/Relationship (Type, Print): Joseph G. Fallon (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Rigdon Rd., Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial GArdens

Date: 7/19/01

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Kirsten A. Urgiesse

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D20215

29d. Date signed (Month, Day, Year): 7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KARMACHANDRA NAIR, M.D. VA MARYLAND HEALTH CARE SYSTEM PERRY POINT

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24350

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: APRIL ELAINE ARMSTRONG FASHAW

2. Date of Death: Month JULY Day 23, Year 2001

3. Time of Death: 2:30 P M

4a. Facility Name *(If not institution, give street and number)*: 10020 EDGEWATER TERRACE

4b. City, Town, or Location of Death: FORT WASHINGTON

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 213-80-2038

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 14,1965

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGES

10c. City, Town or Location: FORT WASHINGTON

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 10020 EDGEWATER TERRACE

10f. Zip Code: 20744

10g. Citizen of Whel Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2 YEARS

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TELEPHONE OPERATOR

16b. Kind of Business/Industry: TELEPHONE ANSWERING SERVICE

17. Father's Name *(First, Middle, Last)*: ROBERT ARMSTRONG

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: NAIMAH LAWTON ROSSANT

19a. Informant's Name/Relationship *(Type, Print)*: NAIMAH ROSSANT / MOTHER

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 10020 EDGEWATER TERRACE, FORT WASHINGTON, MD 20744

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: HUNTT CREMATORY

Date: JULY 24,2001

20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Metastatic Breast Cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other *(specify)* _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Bone MD

29c. License number: D 46285

29d. Date signed *(Month, Day, Year)*: 7/24/01

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): DR. PAUL BONE - 10905 FORT WASHINGTON ROAD, SUITE 206, FORT WASHINGTON, MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 24 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No.: 2001 24351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Gizzi
2. Date of Death (Month, Day, Year): July 18 2001
3. Time of Death: 2:33 a M
4a. Facility Name (If not institution, give street and number): 528 Rowlandsville Road
4b. City, Town, or Location of Death: Conowingo
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 137-12-1821
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 2, 1911
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Conowingo
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 528 Rowlandsville Road
10f. Zip Code: 21918
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Pasika
18. Mother's Name (First, Middle, Meiden Surname): Anna Pribish

19a. Informant's Name/Relationship (Type, Print): Ralph Gizzi/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 528 Rowlandsville Road, Conowingo, MD 21918

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Brookview Cemetery
Date: 7-20-2001
20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen Street, Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Coronary Artery Disease — Immed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Diabetes — Years.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E MD
29c. License number: D0054649
29d. Date signed (Month, Day, Year): July 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. David Baily MD Union Hospital 106 Bow Street Elkton, MD

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24352

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DEMOSTHENES GEORGIOU
2. Date of Death (Month, Day, Year): JULY 20 2001
3. Time of Death: 12:05PM

4a. Facility Name *(If not institution, give street and number)*: DEVLIN MANOR NURSING HOME
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 132-12-3494
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: JULY 20, 1908
9. Birthplace *(State or Foreign Country)*: CYPRUS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: LAVALE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8 HELMAN DRIVE
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, efc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 | Collega (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: COUNTERMAN
16b. Kind of Businass/Industry: FOOD

17. Fether's Name *(First, Middle, Last)*: UNKNOWN
18. Mother's Neme *(First, Middle, Maidan Surname)*: UNKNOWN

19a. Informent's Neme/Reletionship *(Type, Print)*: ALMA GEORGE-WIFE
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8 HELMAN DRIVE, LAVALE, MD 21502

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: SILBAUGH CREMATORY
Dete: JULY 21,2001
20c. Location - City or Town, State: UNIONTOWN, PA

21. Signature of Funeral Service Licensee: Carole S. Hafer
22. Name end Address of Fecility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicefions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or haart failure. List only one ceuse on eech line.

Approximete Interval Batween Onsat end Death

Immedieta Causa (Final disease or condition resulting in deeth)
e. CHF Stage IV — >44yrs
Due to (or es e consequence of):
b. Coronary Artery Disease — >10yrs
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: AFIB, Renal Insufficiency, Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings eveilable prior to complation of cause of death? 1 [ ] Yes 2 [✓] No

25. Wes case refarrad to medical examinar? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, streef, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data and plece, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Dr Khanna
29c. License number: D0054004
29d. Date signed *(Month, Day, Year)*: July 20, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): DR. KHANNA, 1221 NATIONAL HWY, LAVALE, MD 21502

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 23 2001
32. Registrer's Signeture: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kellene Cathy Gohm
2. Date of Death — Month: July; Day: 22; Year: 2001
3. Time of Death: 2345 PM
4a. Facility Name (If not institution, give street and number): SunBridge Care Center
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-74-3543
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 24, 1963
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1 Price Drive
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Writer/Poet
18b. Kind of Business/Industry: Composition

17. Father's Name (First, Middle, Last): Leon W. Laughlin
18. Mother's Name (First, Middle, Maiden Surname): Betty A. King

19a. Informant's Name/Relationship (Type, Print): Betty A. King/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 152 Mill Creek Road, Apt. 1104 Perryville, Maryland 21903

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris & Co. Inc.
Date: July 26, 2001
20c. Location - City or Town, State: West Chester, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Anoxic Encephalopathy
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Aspiration Pneumonia
Due to (or as a consequence of):
c. Spina Bifida
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congenital Hydrocephalus
Sacral decubitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D56820
29d. Date signed (Month, Day, Year): 07/23/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSICK M. NISNISAN MD 223 W. MAIN ST. ELKTON MD 21921

State Registrar

31. Date filed (Month, Day, Year): JUL 24 2001
32. Registrar's Signature: ▶ [signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24354

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linfield Voorhes Hunt, Jr.

2. Date of Death (Month, Day, Year): July 17 2001

3. Time of Death: 11:40 AM

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-18-3452

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 26, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 448 Bailiff Road

10f. Zip Code: 21901

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1948-1950

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Medical Instruments Transportation

17. Father's Name (First, Middle, Last): Linfield V. Hunt, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Anna Gertrude Thompson

19a. Informant's Name/Relationship (Type, Print): Betty C. Hunt/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 448 Bailiff Road, North East, Maryland 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Elkton Cemetery

Date: 7/21/01

20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funeral Service Licensee: Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Bronchiolitis obliterans with organizing pneumonia 4 weeks

Due to (or as a consequence of):

b. Herpes pneumonitis 4 weeks.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Atherosclerotic coronary artery disease
History of Lung cancer

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Mulvey M.D.

29c. License number: D45755

29d. Date signed (Month, Day, Year): 07/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Mulvey, M.D., 111 W. High Street, Elkton, Maryland 21921

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001

32. Registrar's Signature: Brenda D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4+1 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
GLADYS V. HANSON	July 13, 2001	12:06 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	HAvre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
195-26-8142	1☐M 2☐F XX	86 Yrs.			7/19/1914	Oklahoma

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Havre de Grace	1XXYes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
415 S. Market Street	21078	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed XX 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates: XX	1☐Yes XXNo Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Sumner Huffman	Beulah Fitzgerald

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Homer W. Hanson Jr. son	2105 Swartz Rd., Darlington, MD 21034

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1XBurial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baptist View Cemetery	7/17/01	Forest Hill, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Harry P. Hoelider	Harkins F.H.Inc., 600 Main St., Delta PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	1/2 hr.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Norman MD	D32609	7/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamnadu Mithani MD 1106 Revolution St Havre de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

July 13, 2001 1206

Division of Vital Records, P.O. Box 68760,

Hanson, Gladys Virginia 7/14

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24356

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
THOMAS F. HOCTOR	JULY	18	2001	2100

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WM HILL MONOR	EASTON	TALBOT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
075-16-6466	1 [X] M 2 [ ] F	82 Yrs.			NOV 22 1918	NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	ST. MICHAELS	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23754 MT. PLEASANT LANDING CIRCLE	21663	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5+	FOREIGN SERVICE OFFICER	DIPLOMATIC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRANK M. HOCTOR	KATHRYN E. QUIRK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RUTH M. HOCTOR/WIFE	PO BOX 1038 ST. MICHAELS, MD 21663

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)	MD VETERANS CEMETERY	7-25-01	HURLOCK, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ JOHN R. MERCERON CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	Seconds
Due to (or as a consequence of):	b. Acute Myocardial Infarction	Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ASHD with Coronary Artery Disease	5yrs
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Benign Prostatic Hypertrophy

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William Howard MD	D08715	7/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. WOOD, JR. M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended #206, nb, 7/18/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Harold	Lee	Jolley	July 17, 2001	5:02 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital & Medical Center	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
723-07-9689	1☒M 2☐F	73 Yrs.			Jan 18, 1928	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14021 Canal Road SE	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates: WW II	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	PPG Industries

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Arthur Jolley	Sophia (Bierman)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred G. Jolley wife	14021 Canal Road SE;Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Scarpelli Funeral Home	7/18/2001	Cresaptown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARREST	45 MINUTES
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of):	10 YEARS
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robustiano Barrera, Jr.	D0014865	July 17TH 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Medical Building, Suite 201
Dr. Robustiano Barrera, 500 Memorial Avenue , Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	Deputy Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HAROLD JOLLEY 723-07-9689

6

Nes

RJD
FREDERICK KEARSE
01-3756-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #21 PER DVR G798 8/01/01 JH

Certificate of Death

Reg. No. 2001 24358

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Fredrick Elijah Kearse

2. Data of Death Month: JULY Day: 4, Year: 2001

3. Tima of Death: 2042 P.M.

4e Facility Neme (If not institution, giva street and number): 10820 BEAVER DAM RD.

4b. City, Town, or Location of Deeth: COCKEYSVILLE

4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Numbar: 200 60 7835

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 20 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Year): 7 20 80

9. Birthplaca (Stata or Foraign Country): Penn.

Usual Rasidence of Decedant

10a. Stata: Md.

10b. County: Queen Anne

10c. City, Town or Location: Chester

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1215 Little Creek Road

10f. Zip Code: 21619

10g. Citizan of What Country?: U.S.

11. Marital Stetus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify: Black

14. Race - Americen Indien, Black, White, etc. Specify: Black

15. Decedant's Eduction (Specify only highast grada complatad)

Elementary/Secondary (0-12): 12

Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Unknown

16b. Kind of Business/Industry: Unknown

17. Fether's Nema (First, Middle, Last): Joseph Breeding

18. Mothar's Name (First, Middle, Maiden Surneme): Alvera Kearse

19a. Informant's Name/Ralationship (Type, Print): Alvera Kearse (mother)

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1215 Little Creek Chester, Md. 21619

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar place): Union Wesley U.M.C.

Data: 7/102001

20c. Location - City or Town, State: Chester Md.

21. Signature of Funaral Service Licensaa: ERIC L. DASHELL PER DVR.

22. Nama and Address of Facility: ERIC L. DASHIELL F.S. 319 East Dover St. Easton, Maryland 21601

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Entar tha disaesa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory errast, shock, or heart feilure. List only ona causa on each lina.

Approximeta Intarval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death): a. DROWNING

Dua to (or as a consequanca of):

Sequantially list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Diseasa or Injury that initiated evants resulting in death) Last:

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yas 2☐ No

24b. Were autopsy findings available prior to complation of ceusa of death? 1☒ Yes 2☐ No

25. Wes casa rafarred to medical examiner? 1☒ Yas 2☐ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☒ Other (Specify) (SCENE)

27. Manner of Deeth: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year): 7/4/01 FOUND

28b. Tima of Injury: 1940 FOUND M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUBJECT DROWNED

28e. Piece of Injury - At homa, farm, straat, factory, offica building, etc. (Specify): SWIM CLUB / QUARRY

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata): 10820 BEAVER DAM ROAD, COCKEYSVILLE, MD

29a. Cartifiar (Check only one): 1☐ **Certifying Physician:** To the best of my knowledga, daath occurrad at the time, data and place, and due to tha cause(s) and mennar as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner steted.

29b. Signature end title of certifiar:

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Year): JULY 5, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): MARY C. RIPPLE, MD 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Data filed (Month, Day, Year): JUL 12 2001

32. Registrar's Signeture: G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

#21

DHMH 16 Rev 6/95

ORIGINAL

01-3918-001
B.K.S
DAVID KENNEY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001 24359

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Harold Kenney
2. Data of Death Month JULY Day 14, Year 2001
3. Time of Death: 11:56 am
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-68-4161
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct 8, 1955
9. Birthplace (State or Foraign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Ellerslie
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: P.O. Box 361
10f. Zip Coda: 21529
10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yas, Giva Yaar or Datas: 1974-77
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highast greda completad): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Crane Operator
16b. Kind of Businass/Industry: CSX Railroad

17. Fathar's Nama (First, Middle, Last): David Charles Kenney
18. Mothar's Nama (First, Middle, Maiden Surneme): Patricia J (Miller)

19a. Informant's Neme/Relationship (Type, Print): Theresa J. Kenney Wife
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): P.O. Box 361;Ellerslie MD 21529

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cemetary, cramatory or othar placa): Rocky Gap Veterans Cem Date 7/18/2001
20c. Location - City or Town, Stete: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart faitura. List only ona causa on eech lina. — Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in death): e. MULTIPLE INJURIES
Dua to (or as a consaquance of):
Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last:
b. Dua to (or as a consequence of):
c. Dua to (or as a consequanca of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No
24b. Were autopsy findings available prior to completion of causa of daath? 1 [X] Yes 2 [ ] No

25. Was casa rafarred to medical examinar? 1 [X] Yas 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Year): 7-14-2001
28b. Time of Injury: 10:44 AM
28c. Injury at Work? 1 [ ] Yas 2 [X] No
28d. Describe how injury occurred: SUBJECT WAS DRIVER OF TRUCK WHICH WAS STRUCK BY A TRAIN
28e. Piece of Injury - At homa, farm, straat, factory, office building, etc. (Specify): STREET/RAIL ROAD CROSSING
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete): 14308 SCHELLSBURG ALLEGANY COUNTY, MARYLAND

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the causa(s) and manner as steted. 2 [X] Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: Stephen R Radentz, MD
29c. Licansa number: O.C.M.E
29d. Data signad (Month, Day, Year): JULY 15, 2001

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day Year): JUL 20 2001
32. Registrar's Signatura: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
GEORGE H. KNOTTS	JULY 23 2001	00:45 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL & MEDICAL CENTER	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-07-6246	1☒ M 2☐ F	89 Yrs.			APRIL 11, 1912	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	CUMBERLAND	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12 PENNSYLVANIA AVE.	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		TRUCK DRIVER	DAIRY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
STEPHEN KNOTTS	LILLY RICE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GEORGE E. KNOTTS-GRANDSON	P.O. BOX 12, ELLERSLIE, MD 21529

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SUNSET MEMORIAL PARK JULY 26, 2001	CUMBERLAND, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Douglas S Hafer	HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ADVANCE CONGESTIVE HEART FAILURE	> 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIB, DIABETES MELLITUS, TYPE II

HISTORY OF ANEMIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Shiv Khanna MD	D0054004	JULY 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SHIV KHANNA, JOHNSON HEIGHTS MEDICAL BUILDING, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 24 2001	Joyce G Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

MD

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 24361

Wanda Lee Kinnamon
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WANDA LEE KINNAMON
2. Date of Death (Month, Day, Year): July 16, 2001
3. Time of Death: 12:10p.m.

4a. Facility Name (If not institution, give street and number): Memorial Hospital at Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 218-40-5644
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 26, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Tilghman
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6235 Tilghman Island Rd.
10f. Zip Code: 21671
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager
18b. Kind of Business/Industry: Public School
17. Father's Name (First, Middle, Last): Melvin O. Birmingham
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth G. Kelso
19a. Informant's Name/Relationship (Type, Print): John G. Kinnamon Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6235 Tilghman Island Rd. Tilghman, Maryland 21671
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory
Date: July 18, 2001
20c. Location - City or Town, State: Dover , Delaware
21. Signature of Funeral Service Licensee: Harrison E. Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Hone 312 S. Talbot St. St. Michaels, Maryland 21663

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Severe COPD
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HTN
GE Reflux
Osteoporos. with Compressor fracture

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: El-Babe Nega
29c. Licanse number: D46366
29d. Date signed (Month, Day, Year): 07-18-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth Nega M.D. 219 S. WashingtonSt. Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: Jeanine G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ALBERT KENNERLY	JULY 19 2001	1:30 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WM HILL MANOR	EASTON	TALBOT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
113-07-1118	X 1 M 2 F	85 Yrs.			NOV 29 1915	NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	OXFORD	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
305 S. MORRIS ST.	21654	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes X 2 No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5	ARCHITECT	COMMERCIAL & RESIDENTIA ARCHITECTURE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES HOLLAND KENNERLY	HELENE ALBERTS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CAROLINE L. KENNERLY/WIFE	PO BOX 648, 305 S. MORRIS ST. OXFORD, MD 21654

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	CHESAPEAKE CREMATION CTR 7-20-01	STEVENSVILLE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Joseph M. Ostrowski CSFP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory arrest	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Dementia of Alzheimers Type	5 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection
Urinary retention 2/o Benign Prostatic Hypertrophy

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 X Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William H Wood Jr MD	D08715	7/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM H. WOOD, JR. M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Corliss Lochary

2. Date of Death: Month JULY Day 16 Year 2001

3. Time of Death: 8 20 AM

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-07-6183

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 28, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Belcamp

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1254 Collier Lane

10f. Zip Code: 21017

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Joseph Corliss

18. Mother's Name (First, Middle, Maiden Surname): Adeline Anna Witzke

19a. Informant's Name/Relationship (Type, Print): John T. Lochary/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2937 Ebbwood Drive, Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Ignatius Cem.

Date: 7/19/01

20c. Location - City or Town, State: Hickory, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: McComas Funeral Home, P.A 50 West Broadway Street, Bel Air, MD 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Renal Failure — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dehydration — 2 weeks

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rectal bleeding

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier

29c. License number: D 37612

29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMED ALABRASH 1601 S. TOLLGATE RD BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001

32. Registrar's Signature: Geneva G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lochary, Anna

5

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#26 Per Phy. 7-19-01 HCHD LM

Certificate of Death

Reg. No. 2001 24364

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley Lubovsky Levy

2. Date of Death Month Day Year: July 12, 2001

3. Time of Death: 3:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 182-12-5694

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov. 28, 1923

9. Birthplaca *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 200 J Burkwood Court

10f. Zip Coda: 21014

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elamentary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Businass/Industry: Synagogue

17. Fathar's Nama *(First, Middla, Last)*: Abraham Morris Lubovsky

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Esther Ruth Cohen

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Patti Sue Pfau- Daughter

19b. Mailing Address *(Streat and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 5 Roland Place, Bel Air, Maryland 21014

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of cematery, cramatory or othar placa)*: Bel Air Memorial Gardens

Data: 7/15/01

20c. Location - City or Town, Stata: Bel Air, Maryland

21. Signatura of Funaral Service Licensee ▶

22. Nama and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haak failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Daath

Immediata Causa (Finat disaasa or condition resulting in death): a. ACUTE HEMORRHAGIC STROKE — 1 MONTH

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Dua to (or as a consequanca of):

c. Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Rasidanca 6☒ Othar *(Specify)* Transitional care unit

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signature and titla of cartifiar ▶ MD

29c. Licansa number: D45344

29d. Data signed *(Month, Day, Yaar)*: 7/13/01

30. Nama and address of parson who completad causa of daath (Item 23a) (Type, Print): S. DHANJANI, MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

State Registrar

31. Data filed *(Month, Day, Yaar)*: JUL 19 2001

32. Registrar's Signatura ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha daath certificata be axacutad within 24 hours aftar daath.

To the Funaral Director: Aftar this certificata has been signed by tha attanding physician and compliately filled in by tha funaral director, paga 2 should be datachad for usa as tha burial-transit permit. Pagas 1 and 2 should be filad within 72 hours aftar daath with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

1530

7/12/01 JM

Levy, Shirley L.

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24365

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Deborah Sue Lyall

2. Date of Death (Month, Day, Year): July 22, 2001

3. Time of Death: 16:30

4a. Facility Name *(If not institution, give street and number)*: 244 E. High Street

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 213-60-2400

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 15, 1953

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 411 Old Chestnut Road

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Secretary

16b. Kind of Business/Industry: Educational Institution

17. Father's Name *(First, Middle, Last)*: Cecil H. Lilly, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Betty M. Short

19a. Informant's Name/Relationship *(Type, Print)*: Jennifer R. Null/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 68 Welsh Tract Road, #205, Newark, Delaware 19713

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: R.A. Ferris & Co. Inc.

Date: 7/24/01

20c. Location - City or Town, State: West Chester, Pennsylvania

21. Signature of Funeral Service Licensee: Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

rgw

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gallbladder Cancer — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Parents' Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Farkas, MD

29c. License number: D15314

29d. Date signed *(Month, Day, Year)*: July 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Henry Farkas, M.D., 111 W. High Street, Suite 303, Elkton, Maryland 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 24 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Alice E. Leishear	July	18	2001	2:55 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-38-2161	1☐M 2☒F	61 Yrs.					April 08, 1940	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Lonaconing	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15813 Rockville Street	21539	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Aide	Health

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Elmer Getson Sr.	Bertha Jane Bittinger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jack Earl Leishear-Husband	15813 Rockville Street, Lonaconing,Md. 21539

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	The Cumberland Crematory	July 19, 2001	Cumberland,Maryland

21. Signature of Funeral Service Licensee: ▶ Jon C McKenzie

22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md. 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Bilateral Brainstem Infarction	12 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Hypertension	5 years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D21244	July 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jesus H. Tan Frostburg Plaza, Frostburg, Maryland 21532.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ARTHUR THOMAS LANDAKER	JULY 17 2001	21:53 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-20-6016	1☒M 2☐F	74 Yrs.			AUGUST 3 1926	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	ALLEGANY	CUMBERLAND	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
520 PINE AVENUE	21502	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1944-1946	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		CITY OF CUMBERLAND POLICE DEPT.	MAINTANCE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES WILLIAM LANDAKER	ELSIE MAE HOSE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
THOMAS LANDAKER SON	823 ELMWOOD LANE CUMBERLAND MARYLAND 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	ROCKY GAP VET CEMETERY	JULY 23 2001	RFD FLINTSTONE MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dale L. Merritt	MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RESPIRATORY DISTRESS SYNDROME	7 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ASBESTOSIS	YEARS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN, PULMONARY FIBROSIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown		
24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No	

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Hem Shakil MD	D46346	JULY 23 , 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAKIL, HUMA, M.D., 625 KENT AVENUE, SUITE 304, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	Shawn B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ARTHUR T. LANDAKER 215-20-6016

7

TLS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Glenn Eldon Leonard
2. Date of Death: Month 07 Day 17 Year 01
3. Time of Death: 14:15
4a. Facility Name (If not institution, give street and number): Chesapeake Woods
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-28-8562
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 28, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 701 Race Street # 304
10f. Zip Code: 21613
10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Property Manager
16b. Kind of Business/Industry: Public Housing

17. Father's Name (First, Middle, Last): Charles C. Leonard
18. Mother's Name (First, Middle, Maiden Surname): Rose Cannon

19a. Informant's Name/Relationship (Type, Print): Michele Leonard - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5311 First Street Cambridge, Maryland 21613

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory | Date: 7/18
20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Renal cell carcinoma	4months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D53253
29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy J. Snierek MD 503 A MUIR ST Cambridge, MD 21613

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Mildred Estelle Lewis	July 15, 2001	7:30 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Glasgow Nursing Home	Cambridge	Dorchester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-28-0307	1☐ M 2☒ F	86 Yrs.			Oct. 13, 1915	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Dorchester	Cambridge	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
408 Pennsylvania Avenue	21613	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Crab Picker	Seafood

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Gore	Clara Robinson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Clara A. Pritchett	408 Pennsylvania Ave., Cambridge, MD 21613

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	East New Market Cem.	7-18-01	East New Market, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Doreen Curran-Bromwell	Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	SEVERAL YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ B. Paltoo M.D	D0057040	JULY 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Brendon C. Paltoo, 105 Aurora Street, Cambridge, MD 21613

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ G. Spates

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Allan Andrew Moran
2. Date of Death (Month, Day, Year): July 14 2001
3. Time of Death: 6:55 A M
4a. Facility Name (If not institution, give street and number): Upper Chesapeake
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-34-9868
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 22, 1939
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1906 Parkwood Drive
10f. Zip Code: 21050
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 1958
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Field Supervisor
16b. Kind of Business/Industry: A P G

17. Father's Name (First, Middle, Last): Andrew Moran
18. Mother's Name (First, Middle, Maiden Surname): Constance Weber

19a. Informant's Name/Relationship (Type, Print): Phyllis Moran Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1906 Parkwood Drive, Forest Hill, Md. 21050

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus
Date: July 17, 2001
20c. Location - City or Town, State: Balto., Md. 21222

21. Signature of Funeral Service Licensee: Amanda David
22. Name and Address of Facility: Schimunek Funeral Home of BElAir 610 W. MacPhail Rd. Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. End Stage Lung Disease
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul M DO
29c. License number: H55222
29d. Date signed (Month, Day, Year): July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Paul Little 500 Upper Chesapeake Dr Bel Air, Md 21014

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001
32. Registrar's Signature: Bonnie B Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24371

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DAVID ALLEN MURRAY
2. Date of Death Month / Day / Year: July 13 01
3. Time of Death: 05:09
4a. Facility Name *(If not institution, give street and number)*: 211 PERRYWOOD CT APT 304
4b. City, Town, or Location of Death: ABERDEEN
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 215-44-0528
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 3, 1945
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 211 Perrywood Ct. Apt. 304
10f. Zip Code: 21001
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Industrial Parts Manufacturer

17. Father's Name *(First, Middle, Last)*: Allen Winfield Murray
18. Mother's Name *(First, Middle, Maiden Surname)*: Georgia Grindell Lambeth

19a. Informant's Name/Relationship *(Type, Print)*: Esther Marie Honaker / Friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 211 Perrywood Ct., Aberdeen, MD 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. George's Episcopal
Date: 7-20-01
20c. Location - City or Town, State: Perryman, Maryland

21. Signature of Funeral Service Licensee: Charles A. Engel
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PRABHU MD 728 BELAIR RD #134 BELAIR MD 21014.

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 19 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24372

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Margaret Mary Maucher			July	14	2001	1545 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
143 Cherry Hill Road	Elkton		Cecil			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-38-3591	1☐M 2☒F	97 Yrs.					APR 14, 1904	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Elkton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
143 Cherry Hill Road	21921	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	In Her Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Cornelius McCann	Mary Thompson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harry J. Maucher/Son	2024 Singerly Road, Elkton, Maryland 21921

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	R.A. Ferris & Co. Inc.	July 16, 2001	West Chester, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald S. Hicks	Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of Breast with Bone	4-5yrs
	Due to (or as a consequence of): METASTASIS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D44102	7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Renzulli, M.D., 901 Warburton Road, Elkton, Maryland 21921

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	[signature] S. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rev. Louis R. McCartney, O.S.F.S.

2. Date of Death: Month: July; Day: 17; Year: 2001

3. Time of Death: 0715 AM

4a. Facility Name (If not institution, give street and number): Annecy Hall

4b. City, Town, or Location of Death: Childs

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 206-14-4072

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): AUG 31, 1925

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Childs

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1120 Blue Ball Road

10f. Zip Code: 21916

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondery (0-12); College (1-4or 5+): 8+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parish Priest

16b. Kind of Business/Industry: Religious

17. Father's Name (First, Middle, Last): Daniel J. McCartney, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Catherine Anna Smith

19a. Informent's Name/Reletionship (Type, Print): Rev. Francis Hanlon, O.S.F.S.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2200 Kentmere Parkway, Wilmington, Delaware 19806

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Oblate Cemetery

Deta: 7/19/01

20c. Location - City or Town, Steta: Childs, Maryland

21. Signature of Funeral Service Licensee: Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D44102

29d. Date signed (Month, Day, Year): 7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Renzulli, M.D., 901 Warburton Road, Elkton, Maryland 21921

State Registrar

31. Date filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signature: S. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24374

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leslie W. Monroe
2. Date of Death (Month, Dey, Yeer): July 19, 2001
3. Time of Death: 16:00
4e. Facility Name (If not institution, give street end number): 116 Boatyard Road
4b. City, Town, or Location of Death: Chesapeake City
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 089-18-6241
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthdey): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 5, 1907
9. Birthplece (Stete or Foreign Country): Vermont

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Cecil
10c. City, Town or Location: Chesapeake City
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 116 Boatyard Road
10f. Zip Code: 21915
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor
16b. Kind of Business/Industry: Electrical

17. Fether's Neme (First, Middle, Last): Harry C. Monroe
18. Mother's Name (First, Middle, Maiden Surneme): Frances Lackey

19e. Informent's Neme/Reletionship (Type, Print): Lloyd H. Monroe, Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 116 Boatyard Road, Chesapeake City, Maryland 21915

20e. Method of Disposition: 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mettowee Valley Cemetery
Date: July 23, 2001
20c. Location - City or Town, Stete: Pawlet, Vermont

21. Signature of Funeral Service Licensee: ▶ Edward McKeown
22. Name end Address of Feciliity: Gee Funeral Home, 259 E. Main Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth): a. Lung Cancer — 2 months

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury: M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner es steted. ☐ 2 **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ H Farkas, MD
29c. License number: D15314
29d. Date signed (Month, Dey, Yeer): July 20, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): H Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD 21921

State Registrar

31. Dete filed (Month, Day, Year): JUL 20 2001
32. Registrer's Signeture: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AMEND ITEM 26
CECIL CO. 07/13/01 rjw
1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ALLAN DALE MILLER	July 9 2001	1:50 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
EAST BOUND U.S. 40	ELKTON	CECIL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-42-7930	1☑M 2☐F	44 Yrs.			MAY 15, 1957	DELAWARE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CECIL	ELKTON	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
#20 MALVERN DRIVE	21921	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		CARPENTER	CONSTRUCTION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ARTHUR MILLER	ANNA MORRIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY MILLER	#20 MALVERN DRIVE ELKTON MD. 21921

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	R.A. Ferris Crematory	7/13/01	W. Chester PA.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: GEE Funeral Home 259 E. Main St. Elkton, MD.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of Lung	4yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) Car Scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sachdev S. MD	D23322	7.10.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S.S. SACHDEV MD, 118 North St Suite 3B, Elkton MD 21921.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 13 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24376
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Lucille	Ley	Moser	July	16	2001	12:45P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-05-5502	1☐M 2☒F	88 Yrs.			Mar 9, 1913	OH

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
323 Sunset Drive	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Medical Secretary	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leo H. Ley, Sr.	Bertha (Keller)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Richard Moser, Sr. son	126 Eagle Ct HC72 2104;Locust Grove VA 22508

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hillcrest Memorial Par	7/19/2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RENAL FAILURE	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Dehydration	
	Due to (or as a consequence of): c. Urosepsis	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], MD	D0031	July 17 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIRGINIA C. MACRAKIS, MD 9/2 TOWN DRIVE CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

MLS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24377

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
EVELYN JANE MORAN	07 / 19 / 2001	1544 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 34 4522	1☐ M 2☒ F	64 Yrs.			DEC 11 1936	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	FROSTBURG	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15 FROST VILLAGE	21532	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES RANKIN	MABEL GORDON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SANDRA GORDON / DAUGHTER	115 BOWERY ST., FROSTBURG, MD 21532

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Dentition 5☐ Other (Specify)	SCARPELLI FUNERAL HOME, P.A. 7/23/01	CRESAPTOWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis syndrome	one day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Bilateral pneumonia.	one day.
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

Coronary Artery disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wonsock Shin MD	D0055325	July 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN MD. 48 Town Terrace Suite 204 Frostburg, MD 21532

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold William Moore
2. Date of Death (Month, Day, Year): Jul 21, 2001
3. Time of Death: 12:01am

4a. Facility Name (If not institution, give street and number): Cumberland Nursing Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-12-3486
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 4, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 813 Sunbury Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
16b. Kind of Business/Industry: Potomac Edison Co.

17. Father's Name (First, Middle, Last): George Washington Moore
18. Mother's Name (First, Middle, Maiden Surname): Martha W unk

19a. Informant's Name/Relationship (Type, Print): Donna Bauman daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1 Box 120;Wiley Ford, WV 26767

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Scarpelli Funeral Home 2001 — Date: 7/23/
20c. Location - City or Town, State: Cresaptown, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE >5YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b.
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D23371
29d. Date signed (Month, Day, Year): July 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Qamar U Zaman M.D. 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Data filed (Month, Day, Year): JUL 24 2001
32. Registrar's Signature: Virginia D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24379

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Madeline Virginia Maloney
2. Data of Daath — Month: July Day: 14, Yaar: 2001
3. Tima of Daath: 8:10 am
4a. Facility Nama *(If not institution, giva straat and number)*: 5628 Mt. Holly Rd.
4b. City, Town, or Location of Daath: East New Market
4c. County of Daath: Dorchester

Funeral Director

5. Social Security Number: 222-12-4176
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Aug. 24, 1914
9. Birthplace *(Stata or Foraign Country)*: Maryland

Usual Rasidance of Decedant

10a. Stete: Maryland
10b. County: Dorchester
10c. City, Town or Location: Hurlock
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Numbar: 6235 Lords Crossing Rd.
10f. Zip Coda: 21643
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada complatad)* — Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratirad)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Name *(First, Middla, Last)*: Alexander Fitzhugh
18. Mothar's Neme *(First, Middla, Maidan Surnama)*: Carrie Wilson

19a. Informant's Name/Ralationship *(Type, Print)*: Michael J. Maloney/Son
19b. Mailing Addrass *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5628 Mt. Holly Rd., East New Market, MD 21631

20a. Matbod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: OurLadyofGoodCounselCem. — Data: 7-16-01
20c. Location - City or Town, Stata: Secretary, MD

21. Signatura of Funaral Sarvica Licansaa: Colleen Curran-Bromwell
22. Nama and Addrass of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceusa on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediate Causa (Final disaasa or condition rasulting in daath)
a. Congestive Heart Failure — 3yr.
Dua to (or as a consaquanca of):
b. Coronary Artery Disease — 10yr.

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to complation of ceusa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Daath *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidanca 6☒ Othar *(Specify)* Son's residence
27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not ba datarmined
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Data of Injury *(Month, Day Yaar)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurrad at tha tima, deta and place, and dua to the ceuse(s) and mannar stated.

29b. Signatura and tita of cartifiar: Michael J. Fadden
29c. Licansa number: D-26388
29d. Data signed *(Month, Day, Yaar)*: July 16, 2001

30. Nama and Addrass of parson who complatad causa of death (Item 23e) (Type, Print): Michael J. Fadden 302 Collins Ave Hurlock, MD 21643

State Registrar

31. Data filad *(Month, Day, Yaar)*: JUL 18 2001
32. Registrar's Signature: G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item# 10b per fh, bg, 7/26/01
amend item#'s 1 and 17 per fh, bg 7/24/01

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

For State Registrar

Reg. No. 2001 24380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Nelson~~ M. Rawlings Nelson, Sr.
2. Date of Death: Month July, Day 20, Year 2001
3. Time of Death: 0842 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-28-8269
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/20/1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico ~~Somerset~~
10c. City, Town or Location: Eden
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3405 Residential Drive
10f. Zip Code: 21822
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): none
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
18b. Kind of Business/Industry: Seed Sales

17. Father's Name (First, Middle, Last): ~~Welson~~ Weldon M. Nelson
18. Mother's Name (First, Middle, Maiden Surname): Frances W. Nelson

19a. Informant's Name/Relationship (Type, Print): Mary Nelson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 Residential Drive, Eden, MD 21822

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Allen U.M. Cemetery
Date: 07/23/01
20c. Location - City or Town, State: Allen, Maryland

21. Signature of Funeral Service Licensee: James L Hinman M00295
22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Ave., Princess Anne, MD 21853

214-28-8269

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

24. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. progressive supranuclear palsy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
pneumonia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D31540
29d. Date signed (Month, Day, Year): 07/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 106 milford st suite 103 salisbury md 21804

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Merle Nelson

State Registrar

31. Date filed (Month, Day, Year): JUL 24 2001
32. Registrar's Signature: Jenna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Ralph Olin Nelson	July 21 2001	8:39 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-10-4540	1☒ M 2☐ F	90 Yrs.			12-Jun-11	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Frostburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10113 Parkersburg Road, N.W.	21532-	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indien, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	spinner	textile manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Nelson	Rosa Crowe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Rosalie Warnick daughter	317 Allegany Street	Frostburg	Maryland	21532-

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Eckhart Cemetery	24-Jul-01	Eckhart. Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John R Durst	Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis syndrome	5days.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. pneumonia.	5days.
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted.

2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Yeer)
Wonsock Shin MD	D0055325	July 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN 48 Tarn Terrace Frostburg, MD 21532

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 24 2001	Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE DAVID OREM, JR.

2. Date of Death (Month, Day, Year): July 14 2001

3. Time of Death: 219pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-38-4624

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 6, 1938

9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedant

10a. Steta: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 736 Lannerton Road

10f. Zip Coda: 21220

10g. Citizen of What Country?: USA

11. Maritef Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No
If Yas, Giva Yaer or Datas: 1961-63

13. Was Decedent ot Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, Whita, etc.
Specify: White

15. Decedent's Education (Specify only highast grada completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Maintenance

16b. Kind ot Businass/Industry: Public Education

17. Fathar's Nama (First, Middla, Last): George David Orem, Sr.

18. Mothar's Nama (First, Middla, Maidan Surnama): Helen Wanda Borman

19a. Intormant's Name/Ralationship (Type, Print): Geraldine Orem - Wife

19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Coda): 736 Lannerton Road, Baltimore, MD 21220

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Franklinville Presb. Cem.

Date: 7/17/01

20c. Location - City or Town, State: Bradshaw, Maryland

21. Signature of Funaral Service Licensee: Charles A. Smyser

22. Nama and Addrass of Facility: McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not enter the moda ot dying, such es cardiac or respiratory errast, shock, or haart tailura. List only ona cause on each lina.

Approximate Interval Batween Onsat and Death

Immediate Causa (Final disease or condition resulting in daath)
a. Hepatic Hydrothorax — 7 Days
Dua to (or as a consaquanca ot):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Cirrhosis
Dua to (or as a consaquance of):
c.
Dua to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings aveilabla prior to completion of causa ot death? 1 [ ] Yes 2 [ ] No

25. Was casa ratarred to medical axaminar? 1 [ ] Yas 2 [X] No

26. Piece ot Death (Check only ona)
Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA
Othar: 4 [ ] Nursing Home 5 [ ] Rasidence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data ot Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, tactory, offica building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician**: To tha best of *my* knowledge, death occurred at the tima, data and placa, and dua to the cause(s) and mannar as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or invastigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad.

29b. Signature and title of certifiar: X

29c. Licensa number: RD 208116

29d. Data signad (Month, Day, Year): July 14 2001

30. Nama and address ot person who completed causa of death (Item 23a) (Type, Print): DR Marni Klessman 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Data filed (Month, Day, Year): JUL 17 2001

32. Registrar's Signatura: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Orem, George

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24383
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Joanna Lee Patterson	July 18, 2001	9:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurelwood Nursing Center	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
232-40-0579	1☐M 2☒F	70 Yrs.			August 2, 1930	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Rising Sun	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2170 Theodore Road	21911	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Assembly Line Worker	Ordinance Products

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hobart David Patterson	Trudie Frances Drennen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hobart D. Patterson, Jr./Brother	HC 66 Box 203, Hico, West Virginia 25854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Zoar Baptist Church Cemetery	July 21,2001	Kesslers Cross Lane, West Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert D. Crouch	Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

rgw

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Cancer of Breast

Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medicat examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M Saindon MD	D0026183	7.18.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
322 East Cecil Avenue, North East MD 21901

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

1/

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24384

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert M. Plunkett, Sr.

2. Date of Death (Month, Day, Year): July 16, 2001

3. Time of Death: 02:00

4a. Facility Name *(If not institution, give street and number)*: 5 Robert Street

4b. City, Town, or Location of Death: Earleville

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 177-30-5628

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 11, 1938

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Earleville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 5 Robert Street

10f. Zip Code: 21919

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1965-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Barber

16b. Kind of Business/Industry: Hair Cutting

17. Father's Name *(First, Middle, Last)*: John B. Plunkett

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary M. McLoughlin

19a. Informent's Name/Relationship *(Type, Print)*: Marian V. Plunkett/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3405 Janney Avenue, Brookhaven, Pennsylvania 19015

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Lawn Croft Cemetery

Date: 7/20/01

20c. Location - City or Town, State: Linwood, Pennsylvania

21. Signature of Funeral Service Licensee: Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on aech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Acute Myocardial Infarction — Immediate

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b. ASCVD — years

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner es steted. 2 [ ] **Medicaf Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: H Farkas MD

29c. License number: D15314

29d. Date signed *(Month, Day, Year)*: July 16, 2001

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print): Henry Farkas, M.D., Union Hospital of Cecil County, Bow Street, Elkton, MD 21921

State Registrar

31. Dete filed *(Month, Dey, Year)*: JUL 19 2001

32. Registrar's Signetura: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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from

30 + 1 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Emma Frances Powers	July 17 2001	4:35 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Hospital	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-34-0458	1☐ M 2☒ F	61 Yrs.			Oct 5, 1939	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Rising Sun	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
706 Biggs Hwy. #2	21911	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Nursing Assistant	Healthcare

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Lee Alley	Hallie Reva King

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Guy Lee Powers/Husband	706 Biggs Hwy. #2, Rising Sun, MD 21911

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Calvary Baptist Cem.	7-20-2001	Rising Sun, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Richard L. Goodie	R. T. Foard Funeral Home, P. A. 111 S. Queen Street, Rising Sun, MD 21911

Physician /Medical Examiner

rpw

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COPD	>2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Presumptive Myocardial Infarction	1 day
	c.	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastric Ulcer

Cholelithiasis

23e. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No (partial)

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyelcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph K. Weidner Jr. MD	D44373	7/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph K. Weidner, Jr., MD 101 Colonial Way, Rising Sun, MD 21911

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard John Pokorny

2. Date of Death: Month July Day 20, Year 2001

3. Time of Death: 11:50 PM

4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 217-14-9977

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1924

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 700 West Bel Air Avenue, Apt. No. 32

10f. Zip Code: 21001

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Merried 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-44

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): Twelve Years; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Warehouse Manager

16b. Kind of Business/Industry: Bata Shoe Company Belcamp, Maryland

17. Father's Neme (First, Middle, Last): Joseph Pokorny

18. Mother's Neme (First, Middle, Maiden Sumeme): Marie Czecka

19e. Informent's Neme/Reletionship (Type, Print): Richard J. Pokorny, Jr. (son)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1082 Barratts Chapel Road, Felton, Delaware 19943

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): R.A.Ferris & Co.,Inc.

Date: 7/23/01

20c. Location - City or Town, Stete: West Chester, Pennsylvania

21. Signeture of Funerel Service Licensee: ▶ Thomas M. Patterson, Sr.

22. Neme end Address of Fecility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

NAME KNOWN TO PHYSICIAN: POKORNY, Richard

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Carcinoma of Lung — Six Months

Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturet 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end plece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Sodhi

29c. License number: D42014

29d. Date signed (Month, Day, Year): July 23, 2001

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): SURINDERPAL SODHI, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Dete filed (Month, Day, Year): JUL 23 2001

32. Registrar's Signature: ▶ B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2+1 VA

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Mason Proctor	July 18, 2001	12:11A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-30-4947	XX 1 M 2 F	72 Yrs.			March 14, 1929	Washington, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Charles	LaPlata	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10565 Galway Bay Drive	20646	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 XX Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: American Indian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	Washington Suburban Sanitary Commission

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy R. Proctor	Elizabeth Proctor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deborah Proctor/Daughter	10565 Galway Bay Drive LaPlata, Maryland 20646

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Resurrection Cemetery	7/23/01	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Lloyd M. Eaby 191	Adams Funeral Home P.A. Aquasco Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. STAPHYLOCOCCUS AUREUS BACTEMIA	8 DAYS
	Due to (or as a consequence of):	
	c. SUPERIOR VENA CAVAL SYNDROME	8 DAYS
	Due to (or as a consequence of):	
	d. THROMBOSIS	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, END STAGE RENAL DISEASE - DIALYSIS DEPENDENT PERIPHERAL VASCULAR DISEASE.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined			1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Pamela Guha MD.	D0016116	07-18-2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAMELA GUHA 8926 WOODYARD RD #501 CLINTON MD 20735.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	Jeanne G. Gantt

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24388

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS ASBURY PRUITT
2. Date of Death: Month 07 Day 18 Year 2001
3. Time of Death: 2320 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 230-18-0215
8. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1918
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Accomack
10c. City, Town or Location: Tangier
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4378 Gabriel Lane
10f. Zip Code: 23440
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Observer/Tracker
18b. Kind of Business/Industry: Naval Air Bombing Range U. S. Government

17. Father's Name (First, Middle, Last): Willie Frank Pruitt
18. Mother's Name (First, Middle, Meiden Surname): Mamie E. Crockett

19a. Informant's Name/Relationship (Type, Print): Marie Pruitt (Wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 179 - 4378 Gabriel Lane - Tangier, VA 23440

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Testament Cemetery
Date: 7/22/01
20c. Location - City or Town, State: Tangier, Virginia

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt
22. Name and Address of Facility: Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicefions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 1 WEEK
Due to (or as a consequence of):
b. SEVERE AORTIC STENOSIS — -
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditfons** contnbuting to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE, S/P CORONARY ARTERY BYPASS SURGERY, LYMPHOPROLIFERATIVE DISORDER

23e. Did fobacco use contnbute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dalal
29c. License number: 42522
29d. Date signed (Month, Day, Year): 7/18/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Prakash R. Dalal, MD 614 D. Eastern Shore Drive/Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): JUL 24 2001
32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Thomas Pruitt 230 18 0215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Eva Porter	Jul 18, 2001	5:00 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
24013 Kyle Hill Road	Barton	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-74-0752	1☐M 2☒F	86 Yrs.			Dec 27 1914	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Barton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24013 Kyle Hill Road	21521	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Unknown		Minister	Church

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francis Kyle	Anna Mae Lee

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Peggy Saville/Daughter	107 Winnie Place,Gaitherburgs,Md 20877

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Lawn Mem Gar	7/21/01	Cumberland,Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ J Wayne Boal	Boal Funeral Home,111 Church St Westernport,Md 21562

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	20 YRS
	Due to (or as a consequence of):	
	c. HYPER LIPIDEMIA	30YRS
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CHRONIC ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D13601	7/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. V.R. Felipa 925 Bishop Walsh Dr,Cumberland,Md 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24390

Tilghman Rathell

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TILGHMAN LEE RATHELL
2. Date of Death: Month July, Day 14, Year 2001
3. Time of Death: 6:15 AM
4e. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 220-30-0757
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): AUG 27 1926
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10e. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 610 DUTCHMAN'S LANE
10f. Zip Code: 21601
10g. Citizen of Whet Country?: USA
11. Maritel Status: 1 [ ] Never Merried 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER
16b. Kind of Business/Industry: AGRICULTURE
17. Father's Neme (First, Middle, Last): CHARLES REYNOLDS RATHELL, SR.
18. Mother's Neme (First, Middle, Maiden Surname): SARAH PORTER
19a. Informent's Neme/Reletionship (Type, Print): ELIZABETH R. KLINKEN/DAUGHTER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1038 ASHE ST. DAVIDSONVILLE, MD 21035
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Plece of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK
Dete: 7-18-01
20c. Location - City or Town, Stete: EASTON, MD
21. Signeture of Funeral Service Licensee: M. E. Newnam III C.F.S.P.
22. Name end Address of Feciliry: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth)
a. MYOCARDIAL INFARCTION — MINUTES
Due to (or es e consequence of):
b. CORONARY ARTERY DISEASE — YEARS
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.
HYPERTENSION
INSULIN DEPENDENT DIABETES MELLITUS
HYPERLIPIDEMIA.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [✓] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Plece of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Deeth: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and mennor steted.
29b. Signeture and title of certifier:
29c. License number: H48241
29d. Date signed (Month, Day, Year): 7/16/01
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): DANIEL E. MAKAS, DO 8221 TEAL DR, SUITE 204, EASTON, MD 21601

State Registrar

31. Dete filed (Month, Day, Year): JUL 17 2001
32. Registrer's Signeture: Deputy B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Lorenza Roy
2. Date of Death: Month July Day 15 Year 2001
3. Time of Death: 1108 am
4a. Facility Name (If not institution, give street end number): The Kent & Queen Anne's Hospital Inc.
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 222-42-8216
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1958
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 8710 Georgetown Road
10f. Zip Code: 21620
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Soldier
16b. Kind of Business/Industry: U S Army

17. Fether's Neme (First, Middle, Last): Unknown
18. Mother's Neme (First, Middle, Maiden Surneme): Rosemarie Ricks

19a. Informant's Neme/Reletionship (Type, Print): Lillian Boyce / Friend
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8710 Georgetown Road, Chestertown, Maryland 21620

20a. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Capitol Crematory | Dete: 7/19/2001
20c. Location - City or Town, Stete: Dover, Delaware

21. Signeture of Funerel Service Licensee: John T. Prince
22. Neme end Address of Fecility: Bennie Smith Funeral Home, 426 Dover Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death): a. MASSIVE UPPER GI BLEEDING — 6 HRS
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest:
b. PEPTIC HYPERTENSION ESOPHAGEAL VARICES — 3 YRS
Due to (or es e consequence of):
c. CANCER (TRANSITIS)
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospitel: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated. 2 ☐ **Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Julie Seymour MD
29c. License number: D-0013824
29d. Dete signed (Month, Dey, Yeer): 7-15-01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): John Seymur 122 Speer Rd. Chestertown, md. 21620

State Registrar

31. Dete filed (Month, Dey, Yeer): JUL 18 2001
32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24392

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Elizabeth Creighton Riggins
2. Date of Death Month / Day / Yeer: 7 / 18 / 01
3. Time of Death: 0810.
4a. Facility Name (If not institution, give street end number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 219-07-3381
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): May 15 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Taylors Island
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4253 Robinson Neck Road
10f. Zip Code: 21669
10g. Citizen of Whet Country?: U.S.

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): home maker
16b. Kind of Business/Industry: own home

17. Father's Neme (First, Middle, Last): George Earl Creighton
18. Mother's Name (First, Middle, Meiden Surneme): Margie McGlaughlin

19a. Informent's Neme/Reletionship (Type, Print): Roy Riggins son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 184, Taylors Island, MD 21669

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): East New Market cemetery
Date: 7/21
20c. Location - City or Town, Steta: East New Market, MD

21. Signature of Funeral Service Licensee: ▶ Kenneth R. Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): e. ASPIRATION PNEUMONIA — one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. Cerebrovascular Accident — one year
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: ▶ attendy physician
29c. License number: D15541.
29d. Date signed (Month, Day, Year): 7/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vinodrai Mehta, M.D. 402 Byrn St., Cambridge, MD 21613

State Registrar

31. Date filed (Month, Dey, Yeer): JUL 19 2001
32. Registrar's Signature: ▶ Dawn B. Jones

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24393
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Catherine	Sheldon	July 16 2001	1205 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
259-58-2195	1☐M 2☒F	67 Yrs.			May 28, 1934	Alabama

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Churchville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3203 Whitefield Road	21028	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Homemaker	In home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edmund C. McGarity	Georgia Caroline Covington

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lisa Shue (Daughter)	301 Wheel Road, Bel Air, Maryland 21015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bel Air Memorial Gardens	7/20/01	Bel Air, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kenneth B. Bangs	Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SHELDON, CATHERINE M. 8/3

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	24 hours
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Renal Failure	2years
	Due to (or as a consequence of): c. Metastatic Breast Cancer	7 year
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

pathologic cervical spine fractures, pelvic fractures
Hypertension
Depression

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Prashant Shukla MD	D0048050	7/16/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
Prashant Shukla, M.D. 319 S. Union Avenue Havre de Grace MD 21078

18

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #1&4 Per Phy. 7-19-2001 HCHD **Certificate of Death** LM

Reg. No. 2001 24394

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): ~~BETTY SARGABLE~~ Betty Ann Sargable

2. Date of Death: Month 7 Day 16 Year 01

3. Time of Death: 1238 pm

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: ~~BALTIMORE~~

5. Social Security Number: 219-44-7570

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 4, 1944

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3126 James Run Road

10f. Zip Code: 21001

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Roby (NMN) Fowler

18. Mother's Name (First, Middle, Maiden Surname): Edith Agnes Baldwin

19a. Informant's Name/Relationship (Type, Print): Marshall N. Sargable/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3126 James Run Road, Aberdeen, MD 21001

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 7-21-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephen C. Haught

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	1 day
Due to (or as a consequence of):		
b.	PNEUMONIA	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	NON SMALL CELL LUNG CANCER	4 months
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ryan McCormack MD

29c. License number: 13112

29d. Date signed (Month, Day, Year): 7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RYAN McCORMACK MD. 22 South GREENE ST / BALTIMORE, MD 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RUDOLPH F. SCHMICK	July 10, 2001	6:05 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8015 Glendale Road	Chevy Chase	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-01-4163	X 1 M 2 F	93 Yrs.			Nov. 30, 1907	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Chevy Chase	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8015 Glendale Road	20815	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	X 1 Yes 2 No If Yes, Give Year or Dates: 1942-46	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Executive/Sales	Coca-Cola

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Schmick	Catherine Marie Scheurman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth M. Schmick-Wife	8015 Glendale Road, Chevy Chase, MD 20815

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removel from State 4 Donation 5 Other (Specify)	Huntt Crematory	7-13-2001	Waldorf, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John P. Krisley MO1164	Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adenocarcinoma of prostate	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably X Unknown

24e. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 X Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
	District of Columbia MD21837	7-11-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John L. Losee, M.D., 3301 New Mexico Avenue, NW #250, Washington, DC 20016

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24396

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harry Edwin Shobe

2. Date of Death Month / Day / Year: July 19, 2001

3. Time of Death: 10:30 AM

4a. Facility Name *(If not institution, give street and number)*: 702 Holland Street

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 236-03-4419

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 31, 1908

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 702 Holland Street

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 8 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Service Station

17. Father's Nema *(First, Middle, Last)*: Howard W. Shobe

18. Mother's Nama *(First, Middle, Maiden Surnama)*: Lucy B. (Cindy)

19a. Informant's Name/Ralationship *(Type, Print)*: Harry R. Shobe / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12915 Kingbridge Ln., Houston, TX 77077

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Steta 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cematary, crematory or other place)*: Frostburg Memorial Park | Data: 7/23/01

20c. Location - City or Town, State: Frostburg, MD 21532

21. Signature of Funeral Service Licensee: ▶ William S Kight

22. Nama and Address of Facility: Kight Funeral Home, 309-311 Decatur St. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that caused tha daeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart faitura. List only ona cause on aach lina.

Approximate Intarval Between Onset and Death

Immedieta Causa (Final disease or condition rasulting in death)
a. Cerebrovascular Accident — 5yrs

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leading to immadiate causa. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last
b.

Dua to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Daath: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding Invastigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: ▶

29c. License number: D0033280

29d. Data signed *(Month, Day, Year)*: July 19, 2001

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print): Sunil K. Gupta, M. D. 625 Kent Ave., Cumberland, MD 21502

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 23 2001

32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY SAMUEL SINGLETON

2. Date of Death: Month JULY Day 17 Year 2001

3. Time of Death: 12:35 PM

4a. Facility Name (If not institution, give street and number): 106 S. PATTERSON PARK AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 218-32-3307

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUN 30 1936

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 XX Yes 2 ☐ No

10e. Street and Number: 106 S. PATTERSON PARK AVE

10f. Zip Code: 21231

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FACTORY WORKER

16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name (First, Middle, Last): SAMUEL SINGLETON

18. Mother's Name (First, Middle, Maiden Surname): GEORGIA MCCLEARY

19a. Informant's Name/Relationship (Type, Print): SHARON L. BASEMAN/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 241 S. BROADWAY, BALTIMORE, MD 21231

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SPRINGHILL CEMETERY

Date: 7-20-01

20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: Joseph M. Ostrowski CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Coronary artery disease — Six Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chi-Shiang Chen

29c. License number: D-18151

29d. Date signed (Month, Day, Year): July 19, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Chi-Shiang Chen, M.D. 301 St. Paul Pl. #409 - Balto, Md. 21202

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM# 23a per phys G798 080101 ss **Certificate of Death** Reg. No. 2001 24398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Margaret C. Shaw	June 17, 2001	11:50 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-36-2857	1☐M 2☒F	88 Yrs.			Nov. 16, 1912	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
99 Pinecrest Drive	21403	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Secretary	U.S. Navy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Samuel Carr, Jr.	Elizabeth Smith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alvin Shaw / Husband	99 Pinecrest Drive Annapolis, MD 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	Hillcrest Cemetery	6/21/2001	Annapolis, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest ~~Myocardial Infarction~~ 48 Hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD
Dementia

23e. Did tobacco use contribute to the causa of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Steven Resnick	DM35494	6/18/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anne Arundel Medical Center Steven Resnick

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 21 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEMS #23a PTI& 23PTII PER PHY G798 8/01/01 JH **Certificate of Death** Reg. No. 2001 24399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Dey / Yeer	3. Time of Death
FRANCES OLIVE SMITH	JUNE 20, 2001	5:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthpleca (Stete or Foreign Country)
212-38-0608	1☐M 2☒F	83 Yrs.			Dec. 25, 1917	Maryland

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Damascus	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
25513 Ridge Rd.	20872	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Ira L. Fox	Cleva Mae Wolf

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ilene M. Myers/ daughter	303 Redwood Ave. Frederick, MD 21701-6345

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Buriel 2☐Cremation 3☐Removel from State 4☐Donetion 5☐Other (Specify)	Resthaven Mem. Gardens	6/22/01	Frederick, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. COPD Chronic Obstructive Lung Disease with Hypoxemia	2199
Sequentiellly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. markedly Elevated pCO_2 due to COPD	2199
	c. Bibasilar Pneumonia	6101-2wks
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Dey / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Arthritis, BIBASILAR PNEUMONIA

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Dey, Yeer)
John S. Grisson MD	D21944	6/21/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): James S. Grisson MD 300 W. 9th St Frederick, Md 21701

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
JUN 25 2001	Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24400

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Henrietta	L.	Sherbert	July 3, 2001	11:30 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1017 Shore Drive	Edgewater	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
212-30-0195	1☐M 2☒F	69 Yrs.			April 23,1932	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Edgewater	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1017 Shore Drive	21037	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Office Manager	Retail Store

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
E. Frederick Buehner	Deloris Herzberger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
W. Howell Sherbert, Jr./Husband	1017 Shore Drive Edgewater, Maryland 21037

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lakemont Cemetery	7-7-01	Davidsonville, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. BRAIN TUMOR/Glioblastoma Multiforme — 6 wks

Due to (or as a consequence of):
b. SEIZURE DISORDER 2° to #1 — 8-10 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):
c. DEEP VENOUS THROMBOSIS 2° to #1 — 8-10 wks

Due to (or es a consequence of):
d. ASTHMA

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Dey Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	

Pert II. **Other significant conditions** contributing to death but not resulting in lhe underlying cause given in Pert I.

23e. Did tobecco use contribute lo the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ [signature] MD	D31997	7/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Gordon MD 2003 medical Pkwy. Ste 100 Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 06 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24401

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Isabelle Taylor
2. Date of Death (Month, Day, Year): July 20, 2001
3. Time of Death: 7 AM
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air, MD
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-26-1527
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 5, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 601 Cornell Street, Apt. 300
10f. Zip Code: 21001
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
18b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Steward Garland
18. Mother's Name (First, Middle, Maiden Surname): Corinne Jenkins

19a. Informant's Name/Relationship (Type, Print): Jacqueline Greene / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 258 Wilson St., Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. James United Cem.
Date: 7/25/01
20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: ▶ Lisa Scott
22. Name and Address of Facility: Lisa Scott Funeral Home, 552 Lewis Street, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 1S DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): GANGRENE OF FOOT
c. Due to (or as a consequence of): PERIPHERAL VASCULAR DISEASE
d. Due to (or as a consequence of): DIABETES MELLITUS

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ENDSTAGE RENAL DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Nowakowski MD
29c. License number: D08096
29d. Date signed (Month, Day, Year): JULY 21, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): JUL 23 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24402

Olive E. Tayman

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name *(First, Middle, Last)*: Olive Elizabeth Tayman						2. Date of Death Month Day Year: July 19, 2001		3. Time of Death: 3:41AM
4e. Facility Name *(If not institution, give street and number)*: Civista Medical Center			4b. City, Town, or Location of Death: La Plata		4c. County of Death: Charles			
5. Social Security Number: 579-26-5493	6. Sex: 1☐ M 2☒ F	7. Age *(In yrs. last birthday)*: 91 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*: May 26, 1910		9. Birthplace *(State or Foreign Country)*: Maryland	
Usual Residence of Decedent								
10a. State: Maryland	10b. County: Charles	10c. City, Town or Location: Hughesville					10d. Inside City Limits: 1☐ Yes 2☒ No	
10a. Street and Number: 15827 Prince Frederick Road			10f. Zip Code: 20637		10g. Citizen of What Country?: USA			
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*			14. Race - American Indian, Black, White, etc. *Specify:* White			
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): -		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Offset Press Operator			16b. Kind of Business/Industry: US Government Printing			
17. Father's Name *(First, Middle, Last)*: John Sylvester Tayman					18. Mother's Name *(First, Middle, Maiden Surname)*: Marylena Windsor			
19a. Informant's Name/Relationship *(Type, Print)*: Sarah A. Dixon - Niece		19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 321 Rivermont Drive, Waldorf, MD 20602						
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*		20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery			Date: 7-24-01		20c. Location - City or Town, State: Clinton, Maryland	
21. Signature of Funeral Service Licensee: John P. Knisley MO1164			22. Name and Address of Facility: Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156					

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE RESPIRTORY Failure

Due to (or as a consequence of):
b. ACUTE PULMONARY EDEMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. SEPSIS

Due to (or as a consequence of):
d. ISCHEMIC LOWER EXTREMITY from Thromboembolic disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
Samuel Kleiman MD	D26262-MD	7/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel Kleiman, MD 11711 Livingston Road, Fort Washington, MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
JUL 23 2001	G. Goode

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24403

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NORMAN LINWOOD THOMAS
2. Date of Death Month: July Day: 15 Year: 2001
3. Time of Death: 07:45AM
4a. Facility Name (If not institution, give street and number): 2215 BALDWIN MILL RD
4b. City, Town, or Location of Death: FALLSTON
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-14-9919
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 19, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2215 Baldwin Mill Road
10f. Zip Code: 21047
10g. Citizen of What Country?: USA

11. Marital Status: [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: Areospace

17. Father's Name (First, Middle, Last): Martin Luther Thomas
18. Mother's Name (First, Middle, Maiden Surname): Amy Elizabeth Blakley

19a. Informant's Name/Relationship (Type, Print): Wardell Thomas - Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2215 Baldwin Mill Road, Fallston, MD 21047

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem.
Date: 7/18/01
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Holly McComas Pennington
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
DIABETES MELLITUS TYPE II
D/P PACEMAKER CARDIAC

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed (Month, Day, Year): July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GJPNABH M.D. 728 BELAIR MD BELAIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar 3-29-02 JAB AMEND ITEM#18 PER F.H. G805

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Robert Sidney Wenk, Jr.	July	12	2001	7:44 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
20220 Old York Road	White Hall	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
176-30-1639	1☒M 2☐F	67 Yrs.					June 28, 1934	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	White Hall	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20220 Old York Road	21161	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No Korea	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Asbestos Worker	US Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert S. Wenk, Sr.	Edna PENN ~~(Unknown)~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy K. Conley/Daughter	1320 Swingingdale Dr. Silver Spring, MD 20905

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Grove Cemetery	July 16, 2001	Parkton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial infarction	1hr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HBP Due to (or as a consequence of):	years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month	Day	Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown			

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End stage COPD

Suspected cancer of colon

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☐No	1☐Yes 2☐No NA

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
HABERSAT, MD	D18822	7/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
111 Mt Carmel Rd, Parkton, MD 21120

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items#23b,c,d 24b 28a 7/19/01 — *Certificate of Death* HCHD LM — Reg. No. 2001 24405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Joseph Nicholas Wright	July 13, 2001	2:00 pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2711 Laurel Valley Garth	Abingdon	Harford County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-10-8825	1☐M 2☐F X	95 Yrs.			October 13, 1905	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford County	Abingdon	1☐Yes 2☐No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2711 Laurel Valley Garth	21009	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Firefighter	Baltimore City Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Wright, Jr.	Christina Davale

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Katherine Harris/Daughter	2711 Laurel Valley Garth Abingdon, Md 21009

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parkwood Cemetery	7/16/01	Baltimore, Maryland

21. Signature of Funeral Service Licansee	22. Name and Address of Facility
▶ Brian A. Willem	610 W. MacPhail Rd. Bel Air, Md Schimunek Funeral Home of Bel Air, Inc. 21014

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Coronary Artery disease — 4 years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE: N/A 23b. Wes decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy N/A 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery N/A Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Advanced Age

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown	24a. Was en autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No N/A

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year) N/A	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D39889	July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 615 West MacPhail Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Thelma	E.	Walker	July 20, 2001	01:05 a.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross	Silver Springs	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-12-6989	1☐ M 2☒ F	79 Yrs.			Oct.30,1921	Wilm., DE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DE	NewCastle	Wilmington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1303 Tatnall St.	19802	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	n/a	homemaker	housekeeping

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Delplaine Benson	Ethel (Washington) Mason

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Christine H. Lofland	822 N. Monroe St. Wilm., DE 19801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Gracelawn Mem. Park	July 26,2001	NewCastle, DE

21. Signature of Funeral Service Licensee ▶ Robert D. Wright II

22. Name and Address of Facility: The House of Wright Mortuary P.O.Box 447 Wilm.,DE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. arrhythmia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

myocardial infarction

renal insufficiency, Quadriparesis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ G Challa	D42518	7/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gul Chablani 11119 Rockville Pk, S 316 Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	▶ Donna B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24407

ELSIE CHARLOTT WALTERS 218-34-4395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Elsie Charlotte Walters	JULY 16 2001	15:45 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-34-4395	1☐M 2☒F	89 Yrs.			October 29,1911	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
220 Sommerville Ave. Apt 209	21502	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Custodian	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Eugene Gantt	Ida Mae (Durfey)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carole K. Thorpe/ daughter	337 Dorn Ave., Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cumberland Crematory	July 17,2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert C. Adams	Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE CEREBROVASULAR ACCIDENT	10 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASPIRATION PNEUMONIA, CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0033280	JULY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUPTA, SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24408
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOUGLAS ROYCE WILLISON SR.

2. Date of Death Month / Day / Year: JULY 22 2001

3. Time of Death: 20:15 M

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 216-40-3248

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 12 1942

9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 58 MARION STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1964-1989

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ALLEGANY COUNTY ROADS DEPT.

16b. Kind of Business/Industry: MAINTENANCE

17. Father's Name *(First, Middle, Last)*: CLYDE R. WILLISON

18. Mother's Name *(First, Middle, Maiden Surname)*: HAZEL MARIE BENNETT

19a. Informant's Name/Relationship *(Type, Print)*: VICKIE WILLISON WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 58 MARION STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROCKY GAP VETS CEMETERY

Date: JULY 25 2001

20c. Location - City or Town, State: RFD FLINTSTONE MD.

21. Signature of Funeral Service Licensee: Wade L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. VENTRICULAR TACHYCARDIA — 5 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. ATHEROSCLEROTIC HEART DISEASE — 20 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnency 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERLIPIDEMIA

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael D. Zang MD

29c. License number: D0054426

29d. Date signed *(Month, Day, Year)*: JULY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZANG, MICHAEL D., M.D., 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 23 2001

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

DOUGLAS R. WILLISON 216-40-3248

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

13

MD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24409

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carl Elwood Williams
2. Date of Death (Month, Day, Year): Jul 20, 2001
3. Time of Death: 01:30pm
4a. Facility Name *(If not institution, give street and number)*: 316 Arch Street
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 218-16-4374
6. Sex: X 1 M 2 F
7. Age *(In yrs. last birthday)*: 78 Yrs. (If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Sep 12, 1922
9. Birthplece *(State or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: X 1 Yes 2 No
10e. Street and Number: 316 Arch Street
10f. Zip Code: 21502
10g. Citizen of Whet Country?: USA

11. Merital Status: X 3 Widowed (1 Never Married 2 Married 4 Divorced)
12. Wes Decedent Evar in U.S. Armed Forcas?: X 1 Yes 2 No — If Yes, Give Yaar or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 Yas 2 X No *Specify:*
14. Race - Amaricen Indian, Bleck, White, etc.: Specify white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Guard
16b. Kind of Business/Industry: Ballistics Lab
17. Father's Neme *(First, Middle, Last)*: John Thomas Williams
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary G (Masemore)
19a. Informent's Neme/Relationship *(Type, Print)*: Owen M. Williams brother
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 301 W. Industrial Blvd;Cumberland, MD21502
20a. Method of Disposition: X 1 Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Hillcrest Memorial Par
Date: 7/23/2001
20c. Location - City or Town, State: Cumberland, MD
21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth):
a. Ventricular fibrillation — 1minute
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — 10years

Sequantially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest
Due to (or es a consequence of):
c.
Dua to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Cirrhosis of liver

23b. Did tobacco uas contribute to the causes of death?: 1 Yes X 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed?: 1 Yes X 2 No
24b. Were autopsy findings eveileble prior to completion of cause of deeth?: 1 Yes 2 No

25. Wes cese referred to medicel examiner?: 1 Yes X 2 No
26. Place of Death *(Check only one)*: Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home X 5 Residence 6 Other *(Specify)*
27. Menner of Death: X 1 Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work?: 1 Yas 2 No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: X 1 **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end placa, end due to tha ceuse(s) and menner stated.
29b. Signature and title of certifier: ▶ William Lamm MD
29c. License number: D25406
29d. Date signed *(Month, Day, Year)*: July 20, 2001
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): William D. Lamm M.D. 47 Virginia Avenue Cumberland MD 21502

State Registrar

31. Dete filed *(Month, Dey, Year)*: JUL 24 2001
32. Registrar's Signature: Barbara B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary Aileen Yant	July 15 2001	5:30A M

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Health of Bel Air	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
274-09-3117	1☐M 2☒F	91 Yrs.			March 10, 1910	USA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Bel Air	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
311 Rolling Knoll Dr.	21014	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Income Tax Preparation	Tax Preparation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Theodore C. Bayless	Flora Foard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judith Ogle Daughter	311 Rolling Knoll Dr. Bel Air, Md. 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sunset Hills		Canton, Ohio

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Amanda Davis	Schimunek Funeral Home of Bel Air 610 W. MacPhail Rd. Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ David S. Dunn	D32299	July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David S. Dunn 615 W. MacPhail Road

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dr. Haswell

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Wayne Young

2. Date of Death (Month, Day, Year): July 22, 2001

3. Time of Death: 12:40AM

4a. Facility Name (If not institution, give street and number): SunBridge Care Facility

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-24-7618

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 25, 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 104 George Street

10f. Zip Code: 21901

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chrysler

16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Howard Joseph Young

18. Mother's Name (First, Middle, Maiden Surname): Ruth Ann Guiberson

19a. Informant's Name/Relationship (Type, Print): Joseph M. Young Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 234 Independence Drive Elkton, Maryland 21921

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery

Date: 07/26/01

20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funeral Service Licensee: Robert E. Crouch

22. Name and Address of Facility: Crouch Funeral Home 127 South Main Street North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CAD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

NIDDM

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen MD

29c. License number: D54073

29d. Date signed (Month, Day, Year): July 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN STOLE, MD 817 CHURCHMANS CTR NEWCASTLE DE 19720

State Registrar

31. Date filed (Month, Day, Year): JUL 23 2001

32. Registrar's Signature: P. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MADELINE I. R. Y'PINA
2. Date of Death: Month July 16, Day, 2001 Year
3. Time of Death: 7:30 A.M.

4a. Facility Name (If not institution, give street and number): 24862 Swan Rd.
4b. City, Town, or Location of Death: St. MIchaels
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 117-18-0706
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec.8, 1921
9. Birthplace (State or Foreign Country): Buffalo N.Y.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 24862 Swann Rd.
10f. Zip Code: 21663
10g. Citizen of What Country?: U.S,A,

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate
16b. Kind of Business/Industry: Brokerage

17. Father's Name (First, Middle, Last): Hans Wieckle
18. Mother's Name (First, Middle, Maiden Surname): Martha Allwood

19a. Informant's Name/Relationship (Type, Print): James B, Shellem Son in Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2341 Rosedown Dr. Reston , Virginia 21091

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Capitol Crematory
Date: July 17, 2001
20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: Harrison E Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 2 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Insufficiency
Breast Carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mary S DeSheilds MD
29c. License number: D47232
29d. Date signed (Month, Day, Year): 7/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary S. DeSheilds M.D. 509 Idlewild Ave. Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 20b PER FH G798 08/08/01 **Certificate of Death** RR Reg. No. 2001 24413

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Allen
2. Date of Death: Month 7 Day 31 Year 01
3. Time of Death: 2256 M
4a. Facility Name (If not institution, give street and number): Good Samaritan
4b. City, Town, or Location of Death: Balto
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-18-5176
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 22, 1913
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 620 RADNOR AVENUE
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAUNDRESS
16b. Kind of Business/Industry: CLEANING

17. Father's Name (First, Middle, Last): AMOS OWENS
18. Mother's Name (First, Middle, Maiden Surname): PEARL ROYSTER

19a. Informant's Name/Relationship (Type, Print): HELEN HOLLOMAN/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 620 RADNOR AVE., BALTO., MD. 21212

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST V.A.
Date: 08/06/01
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Pyelonephritis — 2 Yrs

Due to (or as a consequence of):
b. Obstructive Nephropathy — 20 Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian Spar MD
29c. License number: D29645
29d. Date signed (Month, Day, Year): Aug 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian Spar MD 6565 N Charles St, Baltimore Md 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001
32. Registrar's Signature: Bonnie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

RR #38 A RR 7

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24414

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIOLA BOZEL

2. Date of Death Month: JULY Day: 29 Year: 2001

3. Time of Death: 4:35pm

4e. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-16-6550

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 27, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4700 Harford Road

10f. Zip Code: 21214

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNK. College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Drug Store

17. Father's Name *(First, Middle, Last)*: UNK.

18. Mother's Name *(First, Middle, Maiden Surname)*: UNK.

19e. Informant's Name/Relationship *(Type, Print)*: Thomas Callahan/Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4016 Belwood Avenue Baltimore, MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc. Date: 8-1-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION. — 9 DAYS

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA
ACUTE RENAL FAILURE
URINARY TRACT INFECTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B Ayi, MD

29c. License number: P13451

29d. Date signed *(Month, Day, Year)*: JULY 29th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERTHA AYI, 5601 LOCH RAVEN BLVD, BALT, MD 21235. GOOD SAMARITAN HOSPITAL

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 0 2 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24415

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Melinda Burns

2. Date of Death Month: 07 Day: 31 Year: 01

3. Time of Death: 0345

4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 126-58-4625

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 24 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 7, 1976

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5213 Saint Albans Way

10f. Zip Code: 21212

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Edward J. Burns

18. Mother's Name *(First, Middle, Maiden Surname)*: Molly M. Gilner

19a. Informant's Name/Relationship *(Type, Print)*: Molly M. Gilner/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5213 Saint Albans Way Baltimore, Md. 21212

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hilltop Service Corp. | Date: 8/4/01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Michael J. Ruck

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Brain Tumor

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brad

29c. License number: AU41764358124JD

29d. Date signed *(Month, Day, Year)*: 7/31/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BIMAL RAMI 22 SOUTH GREENE ST BALTIMORE, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 02 2001

32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte Cowan
2. Data of Death: Month July Day 27, Year 2001
3. Time of Death: 7:15 P.M.
4a. Facility Name (If not institution, give street and number): 3509 Stoneybrook Road
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Maryland

Funeral Director

5. Social Security Number: 217-18-9698
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 9, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 3509 Stoneybrook Road
10f. Zip Code: 21133
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harry J. Read
18. Mother's Name (First, Middle, Maiden Surname): Emma Charlotte Myers

19a. Informant's Name/Relationship (Type, Print): Jack Cowan - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3509 Stoneybrook Road; Randallstown, Maryland 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Pk. Date: 07/31/01
20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature] M00869
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Angina Pectoris

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Recurrent Edema
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D147T3
29d. Date signed (Month, Day, Year): 7/30/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4000 Old Court Road, Baltimore Maryland 21208

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RF

RR 3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEMS #10c,e7f PER DVR 6798 8/02/01 JH

Certificate of Death

Reg. No. 2001 24417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BELLE COGAN
2. Date of Death (Month, Day, Year): July 31ST, 2001
3. Time of Death: 1.30 A M
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-10-7197
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): NOV 10 1917
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: ~~BALTIMORE~~ BALTIMORE
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4529 MARYKNOLL ROAD ~~4529 MARYKNOLL ROAD~~
10f. Zip Code: ~~21208~~ 21208
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HARRY SHULMAN
18. Mother's Name (First, Middle, Maiden Surname): SARA (UNOBTAINABLE)

19a. Informant's Name/Relationship (Type, Print): MRS. SUSAN BLAVATT/ FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3401 NANCY ELLEN WAY OWINGS MILLS, MD. 21117

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH JACOB CONGREGATION Date: 8/1/2001
20c. Location - City or Town, State: FINKSBURG, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEPSIS — 4 DAYS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ JOGINDER P MEHTA M.D
29c. License number: D0041410
29d. Date signed (Month, Day, Year): July 31ST, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001
32. Registrar's Signature: [signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard S. Braswell
2. Date of Death Month Day Year: July 30, 2001
3. Time of Death: 8:15 AM M
4a. Facility Name (If not institution, give street and number): 1020 Lakemont Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-78-6871
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 01, 1966
9. Birthplace (State or Foreign Country): Baltimore, MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1020 Lakemont Road
10f. Zip Code: 21228
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Development Assistant
18b. Kind of Business/Industry: Revisions Behavioral Help

17. Father's Name (First, Middle, Last): Will Braswell
18. Mother's Name (First, Middle, Maiden Surname): Sharon Schriver

19a. Informant's Name/Relationship (Type, Print): Jack Neville
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1020 Lakemont Road, Baltimore, MD. 21228

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balt./Wash. Crematory
Date: 08-02 2001
20c. Location - City or Town, State: Laurel, MD.

21. Signature of Funeral Service Licensee: Rhonda L Lemmer
22. Name and Address of Facility: Witzke Funeral Home/Catonsville 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acquired Immunodeficiency Syndrome
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Janet Horn MD
29c. License number: Md # D25169
29d. Date signed (Month, Day, Year): 7/31/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janet HORN MD 10755 Falls Rd. Ste. 310 Lutherville Md 21093

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24419

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose Marie Coughlin
2. Date of Death Month / Day / Year: July 29 2001
3. Time of Death: 9:12 PM
4a. Facility Name *(If not institution, give street and number)*: 7825 Old Hollow Lane
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 125-30-9283
6. Sex: 1 ☐ M 2 ☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: April 21, 1938
9. Birthplaca *(State or Foraign Country)*: New York

Usual Rasidance of Decedant

10a. Stata: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Insida City Limits: 1 ☐ Yas 2 ☒ No
10e. Street and Number: 7825 Old Hollow Lane
10f. Zip Coda: 21043
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12) / College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Executive Director
16b. Kind of Businass/Industry: Md. New Directions

17. Fathar's Nama *(First, Middla, Last)*: Angelo Miano
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Theresa Spinelli

19a. Informant's Name/Ralationship *(Type, Print)*: James P. Coughlin
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7825 Old Hollow Lane, Ellicott City, MD. 21043

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or othar place)*: Loudon Park Cemetery
Data: 08-02 2001
20c. Location - City or Town, Stata: Baltimore, MD.

21. Signatura of Funaral Sarvica Licansee: ▶ Sandra L Lemmer
22. Nama and Address of Facility: Witzke Funeral Home/Catonsville, 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Cause (Finel disaasa or condition rasulting in daath): a. Uterine Sarcoma — 1 year

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last:
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco uaa contributa to the cause of death? 1 ☐ Yas 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place of Death *(Check only ona)*: Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☒ Rasidanca 6 ☐ Othar *(Specify)*

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending invastigation 6 ☐ Could not be datarmined

28a. Date of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 ☒ **Certifying Physician**: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, date and placa, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of certifiar: ▶ Deborah K. Crusty
29c. Licansa number: D36986
29d. Data signad *(Month, Day, Yaar)*: July 31, 2001

30. Nama and address of parson who complatad causa of daath (Item 23a) (Type, Print): Deborah Armstrong 1650 Orleans St Room 190, Balt MD 21231

State Registrar

31. Data filad *(Month, Day, Yaar)*: AUG 0 2 2001
32. Registrar's Signatura: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24420

Dews Walter G Sr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
WALTER G. DEWS SR.	July 29 2001	8:47P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-38-4655	1☐M 2☐F	59 Yrs.			FEB.15,1942	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	ANNE ARUNDEL	PASADENA	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8350 RITCHIE HWY	21122	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	N/A	PLUMBER	LOCAL 48

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WALTER M. DEWS	LAVERNA L. MALONE

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WALTER G. DEWS JR./SON	8348 RITCHIE HWY, PASADENA, MD 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GLEN HAVEN	8-2-01	GLEN BURNIE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John F. Collins	McCULLY-POLYNIAK FUNERAL HOME P.A. 3204 MOUNTAIN ROAD, PASADENA, MD 21122

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adeno Carcinoma of the Lung	eight months and one year
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or es e consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Wes decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

COR Pulmonale
Congestive Heart Failure
Chronic Obstructive Airway Disease

23e. Did tobecce use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medicaf exeminer?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.
2☐ **Medical Exeminer:** On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ RS Butterfield MD	D37196	July 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. Butterfield 6320 Ritchie Hwy Ste 1 Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 2001	▶ Jeanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24421

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Paulena	Rose	Dougherty	JULY	31	2001	9:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Saint Joseph Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-22-2689	1☐M 2☒F	73 Yrs.					Dec. 21, 1927	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baldwin	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13701 Alliston Drive	21013	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.		Manager	C & P Telephone

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Howard Peters	Catherine Rozina Gayleard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Maureen Tipton / Daughter	511 Upton Road Severn, Maryland 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. John Church Cemetery	8/4/01	Hydes, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Carl D. Fong	Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC NON SMALL CELL	4 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. LUNG CARCINOMA	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Pemy Chhim, M.D.	D26954	07/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEMY CHHIM, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 2001	Jeanne D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24422

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Juanita May Dickens
2. Date of Death (Month, Day, Year): July 19, 2001
3. Time of Death: 0145
4a. Facility Name (If not institution, give street and number): Medstar VNA Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-28-9617
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17, 1931
9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3432 Chestnut Ave
10f. Zip Code: 21211
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert Howell
18. Mother's Name (First, Middle, Maiden Surname): May Howell

19a. Informant's Name/Relationship (Type, Print): Harold Dickens
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3432 Chestnut Ave. Baltimore MD 21211

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation
Date: 7/20/01
20c. Location - City or Town, State: Laurel MD

21. Signature of Funeral Service Licensee: ▶ B. D
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave Laurel MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Emphysema — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher M. Price, MD
29c. License number: D43564
29d. Date signed (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher M Price 3333 N. Calvert St Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William R. Fortune

2. Date of Death (Month, Day, Year): Apr 22, 2001

3. Time of Death: 00:15AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 578-38-1766

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 16 1921

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6236 Light Point Place

10f. Zip Code: 21045

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entrepreneur

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Alfred Fortune

18. Mother's Name (First, Middle, Maiden Surname): Alma Ridgway

19a. Informant's Name/Relationship (Type, Print): Lenata Scott (step-daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6236 Light Point Pl., Columbia MD 21045

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Serv.

Date: 4/23/01

20c. Location - City or Town, State: Sykesville MD

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home &Chapel P.O. Box 195 Sykesville MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Respiratory Failure — 45min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Pulmonary Embolism — minutes

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

right hip fracture, severe osteoporosis, prior right hip fracture (ORIF, 1991) acute myocardial infarction diabetes mellitus, prostate cancer, chr obs. pulmds

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patryce A. Toye, MD Deputy ME

29c. License number: D31473

29d. Date signed (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4505 Hemlock Cone Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #20b PER FH G798 8/08/01 JF

Certificate of Death

Reg. No. 2001 24424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
ROSALIE	M.	GRUZS	AUGUST, 1, 2001	12:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HARBOR HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-36-5506	1☐M 2☒F	61 Yrs.			AUG. 17, 1939	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6483 HERITAGE HILL DRIVE	21061	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		CLERK	MOTOR VEHICLES ADMINISTRATION

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
CASIMIR	GUTOWSKI	STELLA	STYLC

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MS. PAMELA GRUZS (DAUGHTER)	6483 HERITAGE HILL DRIVE, GLEN BURNIE, MD. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHESAPEAKE CREMATION CENTER, LLC	8/04/01	STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Paul Hagan	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER — Approximate Interval: THREE YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mohammed Alattar SECOND YEAR RESIDENT	P 13127	AUGUST. 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED ALATTAR 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 2 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tillie S. Herman
2. Data of Death — Month: July Day: 27, Year: 2001
3. Time of Death: 3:20 P.M.
4a. Facility Name (If not institution, give street and number): Genesis ElderCare-Randallstown
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-12-0423
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct.11,1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9111 Liberty Road
10f. Zip Code: 21133
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: American Can Company

17. Father's Name (First, Middle, Last): Theodore Sutt
18. Mother's Name (First, Middle, Maiden Surname): Mary Revers

19a. Informant's Name/Relationship (Type, Print): Larry Myers Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4719 Deer Park Road; Owings Mills, Maryland 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cemetery
Date: 7/31/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature] M00869
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ARTERY DISEASE	1 HOUR
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. GENERALIZED ARTERIOSCLEROSIS	10 YEARS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- HISTORY OF ATRIAL FIBRILLATION
- HEART FAILURE
- HISTORY OF BREAST CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D-22609
29d. Date signed (Month, Day, Year): JULY 30-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RUBEN REIDER M.D. 7445 FURNACE BRANCH Rd GLEN BURNIE MD 21060

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

RR

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAMIE HAEFFNER

2. Date of Death (Month, Day, Year): AUGUST 01 2001

3. Time of Death: 4:30 PM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 215-07-9869

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 12, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 5401 Plainfield Avenue

10f. Zip Code: 21206

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Machine Shop

17. Father's Name (First, Middle, Last): Charles W. Buckingham

18. Mother's Name (First, Middle, Maiden Surname): Ellen Skoon

19a. Informant's Name/Relationship (Type, Print): George Eber

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Rainflower Path #201 Sparks, MD. 21152

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood

Date: 8/4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature] #100521

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. BRADYCARDIA — 6 HOURS

Due to (or as a consequence of):
b. HEMOPNEUMOTHORAX — 14 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LINE SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D

29c. License number: P-14420

29d. Date signed (Month, Day, Year): AUGUST 01 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): REGINA OSIH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar REPLACEMENT **Certificate of Death** Reg. No. 01-24427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Lance Herling
2. Date of Death (Month, Day, Year): July 22, 2001
3. Time of Death: 2:00 PM
4a. Facility Name (If not institution, give street and number): The Charter House
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 075-12-9879
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 17, 1922
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1316 Fenwick Lane
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian
16b. Kind of Business/Industry: Public Library

17. Father's Name (First, Middle, Last): John Ericson
18. Mother's Name (First, Middle, Maiden Surname): Cornelia Lance

19a. Informant's Name/Relationship (Type, Print): Karene LaGrone
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3014 Hallmark Dr. Gambrills, MD 21054

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Fnd.
Date: 7-24-01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ B, C
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. COLON CANCER — Approximate Interval Between Onset and Death: 1 YEAR

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fatal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Yaar

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) ASSISTED LIVING

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dale and placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D31563
29d. Date signed (Month, Day, Year): August 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles M Benner MD 11251 Lockwood Drive Silver Spring 20901

State Registrar

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: ▶ Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

RKD 01-4162-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

CHRISTOPHER JACOBY UNPENDED 080801: ITEMS#23a,27,28a-f per ME G798 ss AMENDED ITEM#8 per fh G798 080201 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher L. Jacoby

2. Date of Death (Month, Day, Year): JULY 23, 2001

3. Time of Death: 3:51 P.M.

4a. Facility Name (If not institution, give street and number): 4434 FALLS ROAD

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 210-48-5151

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 16, ~~2001~~ 1961

9. Birthplaca (State or Foraign Country): PA

Usual Rasidance of Decedent

10a. Stete: PA

10b. County: York

10c. City, Town or Location: Glenville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 8016 Blooming Grove Rd.

10f. Zip Coda: 17329

10g. Citizan of What Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired): Tree Trimmer

16b. Kind of Businass/Industry: Tree Service

17. Fathar's Nama (First, Middle, Last): Thomas E. Jacoby

18. Mother's Nema (First, Middle, Maidan Surname): Judith A. Sanders

19a. Informant's Name/Ralationship (Type, Print): Judith A. Jacoby/Mother

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): RR #2, Box 2034, Glenville, PA 17329

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of cematary, crematory or othar piece): St. John the Baptist Cemetery

Data: July 26, 2001

20c. Location - City or Town, Stata: New Freedom, PA

21. Signature of Funeral Service Licansee:

22. Nama and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or respiratory errast, shock, or heart feilura. List only one cause on aach line.

Approximata Intervel Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death): a. NARCOTIC INTOXICATION

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last:

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings aveilable prior to complation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarred to medical examinar? 1 [X] Yes 2 [ ] No

26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Residance 6 [X] Othar (Specify) SCENE

27. Mannar of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [X] Could not be determined

28a. Deta of Injury (Month, Day Year) found: 7-23-01

28b. Tima of Injury found: 3:50p M

28c. Injury at Work? 1 [ ] Yas 2 [X] No

28d. Describe how injury occurred: unknown

28a. Ptace of tnjury - At home, ferm, street, factory, office building, atc. (Specify): vehicle

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4434 Falls Rd., Balto., MD

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated. 2 [X] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signatura and title of certifier:

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): JULY 24, 2001

30. Nema and addrass of person who completed cause of daath (Item 23a) (Type, Print): MARYANNE A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Deta filed (Month, Day, Year): AUG 0 2 2001

32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be contacted at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Earl Jones
2. Date of Death: Month July Day 30 Year 2001
3. Time of Death: 4:35 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 239-32-4905
6. Sex: [X] 1 M 2 F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 09 27
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: [X] 1 Yes 2 No
10e. Street and Number: 4445 Pall Mall Road
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 [X] Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes 2 No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Health Aid
16b. Kind of Business/Industry: Baltimore City Health Dept.

17. Father's Name (First, Middle, Last): Eddie Jones
18. Mother's Name (First, Middle, Maiden Surname): Eliza Williams

19a. Informent's Neme/Reletionship (Type, Print): Mary M. Jones-Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4445 Pall Mall Road, Baltimore Md 21215

20a. Method of Disposition: 1 [X] Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)
20b. Plece of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 8/3/01
20c. Location - City or Town, Stete: Baltimore Co, Md

21. Signature of Funeral Service Licensee: Glynn B Keke
22. Name and Address of Facility: March F/H West 4300 Wabash Ave Baltimore Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel disease or condition resulting in death)
a. Intracranial hemorrhage
Due to (or as a consequence of):
b. Hypertension
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 [X] Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as stated. 2 **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: Brian MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): July 30, 2001

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): BRIAN H GALANT MD 2401 WEST BELVEDERE AVE BALTIMORE, MD 21215

State Registrar

31. Dete filed (Month, Day, Year): AUG 0 2 2001
32. Registrer's Signeture: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Patrick known as William Jones

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin J. Kaminski
2. Date of Death Month Day Year: July 31, 2001
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): Manor Care Rossville
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-01-2203
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/10/1911
9. Birthplece (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4315 Raspe Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U,S. Armed Forcas? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipe Fitter
16b. Kind of Business/Industry: American Smelting

17. Fathar's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Sophia (Unknown)

19a. Informant's Name/Relationship (Type, Print): Carol A. Rice/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 4315 Raspe Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Nama of cemetery, crematory or other placa): Balto./Wash. Crematory
Date: 8/2/01
20c. Location - City or Town, Stete: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert J. Modarelli
22. Neme end Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line. Approximete Interval Batween Onset end Death

Immediate Ceuse (Finel disaesa or condition resulting in deeth)
e. Pneumonia
Due to (or es e consequence of):
b. Cerebro-vascular Accident
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
Due to (or es e consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et tha time, data and place, end due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ MD
29c. License number: D53462
29d. Deta signed (Month, Day, Year): 7/31/01

30. Nama end address of person who completed cause of deeth (Item 23a) (Type, Print): Jude Muneses, MD 7845 Oakwood Road Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 2001
32. Registrar's Signetura: ▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24431

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
AUDREY	KAMINSKI	07 / 30 / 2001	1130 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
John Hopkins Bayview Geriatrics	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-16-5091	1☐M 2☑F	81 Yrs.			Nov. 2, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2025 E. Baltimore Street	21231	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Unknown		Manufacturer	Textile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles F. Martin	Virginia Cresswell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Welton Hunt/Friend	Welton Hunt 2027 E. Baltimore St. Baltimore, MD21231

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Louden Park Cemetery	08/03/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kathleen Weber LFSP	David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CVA	9 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

MULTI-INFARCT DEMENTIA

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Michael A. Ankrom M.D.	D46360	July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL A. ANKROM MD 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 2001	▶ Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 4b&c PER FH G798 08/14/01 — **Certificate of Death** RR — Reg. No. 2001 24432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emmy F. Kounz
2. Date of Death — Month: July, Day: 26, Year: 2001
3. Time of Death: 4:15 Am
4a. Facility Name (If not institution, give street and number): Cherry Lane Nursing Home
4b. City, Town, or Location of Death: Laurel
4c. County of Death: P.G County

Funeral Director

5. Social Security Number: 578-28-9840
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 102 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 2, 1899
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11504 Nevis Dr.
10f. Zip Code: 20705
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 4+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: National Science Foundation
17. Father's Neme (First, Middle, Last): Herman Heller
18. Mother's Neme (First, Middle, Maiden Surneme): Maria Meesen
19a. Intormant's Name/Relationship (Type, Print): Margrit Mason
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11504 Nevis Dr. Beltsville MD 20705
20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removel from State 4☒ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Anatomic Gift Foundation — Date: 7/26/01
20c. Location - City or Town, Stete: Laurel, MD
21. Signature of Funeral Service Licensee: ▶ B, O
22. Name end Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart teilure. List only one ceuse on eech line. — Approximate Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in deeth): a. Coronary Artery disease — Due to (or es e consequence of): — N/S

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, term, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) snd manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) snd menner steted.

29b. Signature and title of certifier: ▶ N. Jan MD
29c. License number: D41978
29d. Date signed (Month, Day, Year): 7-27-2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Nadel Javakoli 4000 Mitchellville Rd #312 Bowie MD 20716

State Registrar

31. Dete filed (Month, Day, Year): AUG 0 2 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John James Murphy
2. Date of Death (Month, Day, Yaar): July 28, 2001
3. Time of Death: 6:30pm
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 289-09-5122
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 2, 1916
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10881 York Road
10f. Zip Code: 21030
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 42'-46'
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manufacturer's Rep./Engineer
16b. Kind of Business/Industry: Heavy Industrial Equipment

17. Father's Nama (First, Middla, Last): Louis Francis Murphy
18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Murphy

19a. Informant's Name/Relationship (Type, Print): Daughter Kay Murphy Ruppersberger/
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Highfield Ct. Cockeysville, MD 21030

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory, or othar place): Dulaney Valley Memorial Gardens
Date: July 31, 2001
20c. Location - City or Town, Stata: Timonium, MD

21. Signature of Funaral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feture. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Dua to (or as a consaquance of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings availabla prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier
29c. License number: D43725
29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Yaar): AUG 0 2 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

July 28, 2001 6:30 p.m.
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, John Murphy

RR

RR 4+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 24434

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy D. Mowers	July 23, 2001	11:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1701 Glencoe Road	Glencoe	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-01-2069	1☐M 2☒F	90 Yrs.			March 14, 1911	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Dickeyville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2318 Tucker Ln.	21207	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	N/A	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Dillow	Catherine Keats

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ellen Turnball/ daughter	1701 Glencoe Rd., Glencoe, MD 21152

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lorraine Park Cemetery	7-26-01	Woodlawn, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Bryan W. Clary per DVR	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ M.D.	D 50859	7/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Timothy Doyle, 7801 York Road, Suite 102, Towson, Maryland 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 2 2001	Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Rosalie Myers	July 28, 2001	9:50 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare-Heritage	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-34-7497	1☐M 2☒F	65 Yrs.			May 24, 1936	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6207 Toone Street	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kirtd of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry J. Everhart	Lillian P. Lashear

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Ramona Goralski/Daughter	248 S. Wolfe St. Baltimore, Maryland 21231

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Meadowridge Memorial	08/01/01	Elkridge Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kathleen Weber CFSP	David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d. Due to (or as e consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) _____ 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

STROKE, SEIZURE DISORDER, G-TUBE, DEMENTIA

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.
2☐**Medical Examinar:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D52360	7/30/01

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) KULBIR SANDHU
18356 GREENTREE RD. SUITE 300 PIKESVILLE MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 2001	▶ Geneva B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

ORIGINAL

01-4282-510
jhm
ROBINSENA
MALORY AMEND ITEM#23a-ptII per ME G798 082201 ss
UNPENDED 080801:ITEMS#23a,27,28a-f perME G798 ss

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robinsena Malory	JULY 30, 2001	01:03 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHN HOPKINS HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-78-5921	1☐M 2☒F X	40 Yrs.			NOV 9, 1960	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes X 2☐No

10a. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3520 Cliftmont Avenue	21213	USA

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced X	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No X Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Claims	State of Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Lee Lewis	Emily Loretta Smalls

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Deon Tony Wilson/Son	3520 Cliftmont Avenue Baltimore, MD 21213

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory Inc.	8-1-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas Gregor	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA

23b. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was cese referred to medical examiner? 1☒Yes 2☐No

26. Place of Deeth (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☒Could not be determined	7-29-01	unknown M	1☐Yes 2☒No	unknown

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)
unknown	unknown

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner as steted. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ J Pestaner MD	OCME	JULY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 2001	Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard McGinn

2. Date of Death Month 07 Day 29 Year 01

3. Time of Death 1645 M

4a. Facility Name (If not institution, give street and number): University Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 218-36-7660

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-4-40

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8103 Beechberry Court Apt.#1007

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Metal Industries

17. Father's Name (First, Middle, Last): Melvin G. McGinn Sr.

18. Mother's Name (First, Middle, Maiden Surname): Anna F. Rittersofer

19a. Informant's Name/Relationship (Type, Print): Gloria M. McGinn (spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8103 Beechberry Ct. Apt. 1007, Pasadena, MD. 21122

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Maryland Veterans Cem

Date: Aug. 1 2001

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death): a. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] A.H. Toledo

29c. License number: AU41761357T13156

29d. Date signed (Month, Day, Year): 07/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): University Maryland Medical Center 22 S. Greene St. 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry R. Nesbitt, Jr.

2. Date of Death Month Day Year: JULY 31, 2001

3. Time of Death: 4:00 A M

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-28-4791

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 12, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Monkton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 15818 Carroll Road

10f. Zip Code: 21111

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Furniture

17. Father's Name (First, Middle, Last): Harry R. Nesbitt, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Helen F. Fleming

19a. Informant's Name/Relationship (Type, Print): L. Virginia Nesbitt/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15818 Carroll Road Monkton, MD 21111

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: August 3, 2001

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Encephalopathy — 1 day

Due to (or as a consequence of):

b. Cardiopulmonary Arrest — 1 day

Due to (or as a consequence of):

c. Ischemic Cardiomyopathy — 8 years

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0057444

29d. Date signed (Month, Day, Year): July 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander Chen MD. 6701 N Charles St Rm 3853 Towson 21204

State Registrar

31. Date filed (Month, Day, Yeer): AUG 0 2 2001

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Department of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Dey	Year	3. Time of Death
Lorenza W. Norwood, Jr.	July	31,	2001	6:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Villa Nursing Home	Catonsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
214-05-5137	1☒M 2☐F	83 Yrs.			Jan 26,1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1☐Yas 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
711 Academy Road	21228	USA

11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12		Electronic Engineer	Westinghouse

17. Fathar's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Meiden Surname)
Lorenza W. Norwood, Sr.	May Lody

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Santos Daughter	1401 Lafayette Ave. Baltimore, MD 21207

20e. Method of Disposition	20b. Placa of Disposition (Name of cemetery, cremetory or othar pleca)	Dete	20c. Location - City or Town, Stete
1☐Burial 2☒Cremation 3☐Removel from State 4☐Donation 5☐Dther (Specify)	Balto. Wash. Crematory	8/2/2001	Laurel, Maryland

21. Signature of Funerel Service Licensee ▶ Jennifer Scheu

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Daath
Immediate Cause (Finel disease or condition resulting in deeth)	a. Carcinoma of oral cavity	1 year
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or es a consequenca of):	
	d. Due to (or es a consequenca of):	

IF FEMALE: 23b. Wes decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yas 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent at time ot deeth 5☐Other (specify) 9☐Unknown	

Pert II. **Dthar significant conditions** contnbuting to deeth but not resulting in tha undarlying causa given in Part i.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause ot death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case relerred to medical exeminer?	28. Placa of Daath (Chack only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Dther: 4☒Nursing Home 5☐Residance 6☐Other (Specify)

27. Menner of Death	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurrad
1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place ot Injury - At home, tarm, street, tectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end pleca, and due to the cause(s) end menner es stated. 2☐ **Medical Examinar:** On tha basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Charles R Graham Jr MD	D24781	August 1st, 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print) CHARLES R. GRAHAM JR 1001 PINE HEIGHTS AVE SUITE 300 BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
AUG 02 2001	▶ Brenda D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

441

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Shirley	M.	Neidert	July	31	2001	10:45A M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-52-3525	1☐M 2☒F	54 Yrs.			June 11 1947	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Lothian	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
253 Rips Drive	20711	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Driver	A.A. Co. Dept of Aging

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
Theodore	Woodrow	Neidert	Alverta	E. Jenkins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jennifer L. Neidert daughter	253 Rips Drive Lothian MD 20711

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory Inc	8/3/01	Baltimore MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LIVER CIRRHOSIS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. HEPATITIS C	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D43977	July 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ayoka Owumi 301 Hospital Drive Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

NEIDERT Shirley

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24441

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: MICHAEL PHILLIPS
2. Dete of Death Month: 6 Day: 3 Year: 01
3. Time of Deeth: 1430?
4e. Facility Neme *(If not institution, give street and number)*: CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTMINISTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: Ø
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)* Yrs.: If Under 1 Yaar Months / Days; If Under 24 Hrs. Hours / Min: 30
8. Dete of Birth *(Month, Dey, Yeer)*: 6/5/01
9. Birthplace *(Stete or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: CARROLL
10c. City, Town or Location: FINKSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2831 CEDARHURST RD
10f. Zip Code: 21048
10g. Citizen of Whet Country?: USA

11. Maritel Status: 4 — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 2 — 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indian, Bleck, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): Ø; College (1-4or 5+): Ø
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ø
16b. Kind of Business/Industry: Ø
17. Fether's Name *(First, Middle, Last)*: THOMAS SHEPPARD PHILLIPS
18. Mother's Nema *(First, Middle, Maiden Surnama)*: KELLY JEAN PHILLIPS
19a. Informent's Name/Relationship *(Type, Print)*: Mr. Thomas S. Phillips Father
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2831 Cedarhurst Road Finksburg, MD 21048
20e. Method of Disposition: 2 — 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Carroll Cremation Serv.
Dete: 6/6/01
20c. Locetion - City or Town, Stete: Hampstead, Maryland
21. Signature of Funeral Service Licensee: Stephen M. Jenkins
22. Nama and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that ceused the death. Do not enter tha mode of dying, such es cerdiac or raspiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onsat end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. PREMATURITY

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other signifIcent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performad? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilebla prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatiant 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey, Yeer)*: Ø
28b. Time of Injury: Ø M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Ø
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Ø
28f. Locetion *(Street and Number or Rural Route Number, City or Town, State)*: Ø

29a. Certifier *(Check only one)*: 1☐ **Certifying Phyelcien**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et tha time, date and place, end dua to the ceuse(s) end menner stated.

29b. Signature and title of certifier: MR Barnett MD
29c. Licensa number: D34916
29d. Date signed *(Month, Dey, Yeer)*: 7/11/01

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print): MICHAEL R BARNETT 295 STONER AVENUE WESTMINSTER, MD 21157

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: AUG 0 2 2001
32. Registrer's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

K.B.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Mary E. Peters	July 31, 2001	9:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Med. Ctr.	Baltimore	N/A

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-22-7250	1☐M 2☒F	87 Yrs.			Oct. 17, 1913	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20 S. Robinson Street	21224	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Home Maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John A. Tierney	Margaret Cusick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathy Snello / Niece	8901 Talc Dr.,Apt. 2 C, Balto.,Md. 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	New Cathedral Cemt.	8-3-01	Balto.,Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert J. Paddack Jr.	Moran-Ashton Funeral Home, Inc. 3000 E. Baltimore St.,Balto.,Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arrhythmia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): AFIB Ex Ballchen	
	c. Due to (or as a consequence of): ASCVD	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D 24276	08 02 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Simon Scalia M.D. 2801 Hudson Street Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 0 2 2001	▶ Donna D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM #23a PER PHY G798 8/08/01 JH
AMEND ITEM #18 PER FH G798 8/02/01 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
SARAH DOYLE PATE	July 29, 2001	4:18 PM

4e Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan Hospital	Baltimore City	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar Months	If Under 1 Yaar Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplace (Stete or Foreign Country)
252-30-2606	1☐ M 2☒ F XX	88 Yrs.					8/16/1912	Mississippi

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Cockeysville	1☐ Yes 2☒ No XX

10a. Street and Number	10f. Zip Code	10g. Citizan of What Country?
11824 Falls Road	21030	United States

11. Merital Stetus	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Naver Merried 2☐ Married 3☒ Widowed XX 4☐ Divorced	1☐ Yes 2☒ No XX If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No XX Specify:	Specify: White

15. Decedent's Eductetion (Specify only highest grede completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	5+	Teacher	Education

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)
Dennis Fort Doyle	MARY LETITIA BRANNAN ~~Mary Brennan Doyle~~

19a. Informant's Name/Reletionship (Type, Pnint)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Mrs. Penelope Scott/daughter	11824 Falls Road Cockeysville, MD 21030

20e. Mathod of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Othar (Specify)	Dulaney Valley Mem. Grdn	08/02/2001	Timonium, MD

21. Signature of Funeral Service Licensee	22. Neme end Addrass of Fecility
[signature]	Ruck Towson Funeral Home. Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth)	a. ~~SEPSIS~~ HYPOXIC RESPIRATORY FAILURE	4 MINS ~~4 DAYS~~
	Due to (or es e consequence of):	
	b. ASPIRATION OF GASTRIC CONTENTS	1 Hour
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Last	Due to (or as a consequence of):	
	c. CHANGE IN MENTAL STATUS FROM ONGOING SEPSIS	24 HOURS
	Due to (or as e consequence of):	
	d. SEPSIS	4 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

SICK SINUS SYNDROME WITH PACER
STATUS POST CAROTID ENDARTERECTOMY (RIGHT)
HYPERTENSION

23b. Dfd tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings availeble prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical exeminar?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD.	P13451	JULY 29TH 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 5601 LOCH RAVEN BLVD
BERTHA AYI, MD BALTIMORE, MD, 21239.

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrer's Signetura
AUG 0 2 2001	[signature] D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Peay

2. Date of Death: Month July Day 31 Year 2001

3. Time of Death: 1:30 PM

4a. Facility Name (If not institution, give street and number): Joseph Ritchie House

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: none

Funeral Director

5. Social Security Number: 215-32-6350

6. Sex: 1☐ M 2☒ F

7. Age (In yrs, last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 22, 1906

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Jessup

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7960 Jones Road #32

10f. Zip Code: 20794

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: In Truck Company

17. Father's Name (First, Middle, Last): HAZEL Byrd

18. Mother's Name (First, Middle, Maiden Surname): Julia Foster Byrd

19a. Informant's Name/Relationship (Type, Print): Lonnie Paye

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7960 Jones Road #32 Jessup, Maryland 20794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: 8/4/01

20c. Location - City or Town, State: Arbutus, Maryland

21. Signature of Funeral Service Licensee: Nancy M. Wallace

22. Name and Address of Facility: NANCY M. WALLACE FUNERAL SERVICE 3405 W. FRANKLIN St. BALTIMORE, MARYLAND 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CVA — Approximate Interval: 6 MO

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify): Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John K. Payne, MD

29c. License number: D13012

29d. Date signed (Month, Day, Year): July 31, 01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): John Payne 6565 N. Charles St, Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 02 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1:30 pm 7/31/01 Alice Peay

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret E. Randle

2. Date of Death (Month, Day, Year): August 1, 2001

3. Time of Death: 1:10 PM

4a. Facility Name (If not institution, give street and number): 2506 Frank Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-07-4296

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): APR 20, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3013 Ferndale Avenue

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Proof Reader

16b. Kind of Business/Industry: Retail Store

17. Father's Name (First, Middle, Last): Millard Litsinger

18. Mother's Name (First, Middle, Maiden Surname): Eloise Fiffel

19a. Informant's Name/Relationship (Type, Print): Patricia Smith/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2506 Frank Avenue Baltimore, MD 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 8-4-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 1 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wm C Wakefield MD

29c. License number: 024356

29d. Data signed (Month, Day, Year): August 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wm C WAKEFIELD MD St Agnes Cancer Center 900 Caton Ave, Baltimore Md 21229

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RR

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State Registrar

31. Data filed (Month, Day, Year): AUG 0 2 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24446

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRY R. SYLCE

2. Date of Death: Month AUGUST Day 01 Year 2001

3. Time of Death: 1:40 P M

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 008-03-7121

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 14, 1916

9. Birthplace *(State or Foreign Country)*: VERMONT

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No — X

10e. Street and Number: 800 SCOTT CIRCLE

10f. Zip Code: 21060

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — X
If Yes, Give Year or Dates: WWII KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No — X *Specify:*

14. Rece - American Indien, Bleck, White, etc.
Specify: WHIE

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CIVIL SERVICE

16b. Kind of Business/Industry: DEFENSE

17. Father's Name *(First, Middle, Last)*: JOHN SYLCE

18. Mother's Name *(First, Middle, Maiden Surname)*: BLANCHE BRADLEY

19a. Informant's Name/Relationship *(Type, Print)*: STEVEN R. SYLCE /SON

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 8054 HIGH OAK ROAD, GLEN BURNIE MARYLAND 21060

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State — X
4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: GLEN HAVEN MEM. PARK

Date: AUG. 6, 2001

20c. Location - City or Town, Slete: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: Kirk E Bauer

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A.
421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiralory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Belween Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumothorax

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or as a consequence of): Lung Cancer
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of deeth 5 ☐ Other *(specify)* 9 ☐ Unknown

23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribule lo the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown — X

24a. Was en eutopsy performed? 1 ☐ Yes 2 ☒ No — X

24b. Were eutopsy findings evaileble prior lo completion of cause of deeth? 1 ☐ Yes 2 ☒ No — X

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No — X

26. Place of Death *(Check only one)*
Hospital: 1 ☒ Inpatient — X 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural — X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. — X
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the lime, date end place, end due lo the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D48006

29d. Date signed *(Month, Day, Yeer)*: August 1st, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BOAITEY, 301 Hospital Dr., Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 02 2001

32. Registrar's Signature: G. Spates

DHMH 17 Rev 1/2001

ORIGINAL

SYLCE HARRY

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #11 PER FH G 798 8/09/01 JH

Certificate of Death

Reg. No. 2001 24447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Abercrombie Seymour
2. Date of Death (Month, Day, Year): July 24, 2001
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): 15 Charles Plaza Apt. 2207
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-03-2901
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/3/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 15 Charles Plaza Apt. 2207
10f. Zip Code: 21201
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Investigator
16b. Kind of Business/Industry: Cable Telephone Mfg.

17. Father's Name (First, Middle, Last): William S. Seymour M.D.
18. Mother's Name (First, Middle, Maiden Surname): Leila Martin

19a. Informant's Name/Relationship (Type, Print): Rose Cooper
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 St. Paul Street P.O. Box 17034 Balto. MD 21297

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto./Wash. Crematory
Date: 7/31/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert D Podach
22. Name and Address of Facility: Bradley/Ashton/Matthews Funeral Home Inc. 2134 Willow Spring Road Dundalk, MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ William M Smith
29c. License number: D11867
29d. Date signed (Month, Day, Year): 7/25/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. M. Smith MD 706 E. Lexington St. Balto. Md 21202

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 2001
32. Registrar's Signature: ▶ Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alverta Washington
2. Date of Death (Month, Day, Year): July 27 2001
3. Time of Death: 2:00p.m.
4a. Facility Name (If not Institution, give street and number): 4406 Old Frederick Road #B
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-18-3470
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 14 16
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 4406 Old Frederick Road #B
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Agent
16b. Kind of Business/Industry: American Realty Co.

17. Father's Name (First, Middle, Last): Charles H. Harris
18. Mother's Name (First, Middle, Maiden Surname): Minnie Chatman

19a. Informant's Name/Relationship (Type, Print): Allen R. Washington-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 Wicklow Road, Baltimore Md 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bethel Baptist Ch. Cemetery
Date: 8/1/01
20c. Location - City or Town, State: Gloucester, VA

21. Signature of Funeral Service Licensee: ▶ Robert E Day
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Probable acute arrythmia

Due to (or as a consequence of):
b. Chronic Obstructive Lung Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. History of Atrial fibrillation

Due to (or as a consequence of):
d. Systemic lupus erythematosus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: previous TIA; aortic insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gary B. Ruppert MD
29c. License number: D18446
29d. Date signed (Month, Day, Year): July 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): 301 St. Paul Place #411 Balto MD 21202

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 2001
32. Registrar's Signature: ▶ Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24449

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norman Reginald Winder

2. Date of Death — Month: August Day: 1 Year: 2001

3. Time of Death: 855 AM

4a. Facility Name *(If not institution, give street and number)*: Union Mem. Hosp

4b. City, Town, or Location of Death: Balto

4c. County of Death: N. A

Funeral Director

5. Social Security Number: 213 64 6883

6. Sex: 1 M 2 F

7. Age *(In yrs. last birthday)*: 46 Yrs.

If Under 1 Year — Months / Days; If Under 24 Hrs. — Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4/22/55

9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: N. A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1 Yes 2 No

10e. Street and Number: 905 N. Central Ave

10f. Zip Code: 21202

10g. Citizen of What Country?: U. S. A

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Roofer

18b. Kind of Business/Industry: Contractor

17. Father's Name *(First, Middle, Last)*: William Winder

18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Roy

19a. Informant's Name/Relationship *(Type, Print)*: FRANCES WINDER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 905 N. Central Ave Balto Md. 21202

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Cem. Date: 8/2/01

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph G. Locke II

22. Name and Address of Facility: Joseph G. Locke & F/H, 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 20 minutes

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Arrythmia

Due to (or as a consequence of):
b. Dilated cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other *(specify)* 9 Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

28. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 8 Other *(Specify)*

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Nguyen M.D.

29c. License number: 2438946-B11

29d. Date signed *(Month, Day, Year)*: August 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stephen Nguyen 201 East University Parkway, Baltimore Maryland 21218

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 0 2 2001

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-3950-013
JOHN W. AMASS
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN W. AMASS
2. Date of Death: Month JULY Day 16 Year 2001
3. Time of Death: 2213
4a. Facility Name (If not institution, give street and number): 2620 OLD WASHINGTON RD.
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-80-5167
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 29 1961
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2620 Old Washington Rd.
10f. Zip Code: 21157
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Ampco Plumbing
17. Fether's Name (First, Middle, Last): Arnold Amass
18. Mother's Name (First, Middle, Maiden Surname): Patricia Richter
19a. Informent's Neme/Relationship (Type, Print): Mr. Arnold Amass Father
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Fitzhugh Ave. Westminster MD 21157
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Meadow Branch Cemetery
Date: 7/24/01
20c. Location - City or Town, State: Westminster, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Pritts Funeral Home and Chapel P.A. 412 Washington Road Westminster, MD 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. CONTACT GUNSHOT WOUND OF HEAD
Due to (or as a consequenca of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest
b.
Due to (or as a consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE
27. Menner of Deeth: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year): 7/16/01
28b. Time of Injury: 2131 M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT SHOT SELF
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 2620 OLD WASHINGTON R.D, WESTMINSTER, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JULY 17, 2001

WJL 10-8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JUL 23 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24451

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henry L. Adams, III

2. Date of Death Month Day Year: July 14, 2001

3. Time of Death: 1545

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-07-7937

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov. 7, 1918

9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidanca of Decedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 1018 Baltimore Road

10f. Zip Coda: 20851

10g. Citizan of What Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): 12; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Budget Analysis

16b. Kind of Businass/Industry: U.S. Government

17. Fathar's Nama *(First, Middla, Last)*: Henry L. Adams, Jr.

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Mary Wright

19a. Informant's Name/Ralationship *(Type, Print)*: Kerry S. Adams/Son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 12803 Locbury Circle, Apt. K, Germantown, MD 20874

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Gate of Heaven Cemetery

Data: July 18 2001

20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funeral Service Licansee: David E. Perry . M00803

22. Nama and Addrass of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath): e. Acute Myocardial Infarction — 12 Hours

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Malignant Lymphoma

Renal Insuffiency

Chemotherapy-induced Pancytopenia

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to madical examinar? 1 [ ] Yes 2 [X] No

26. Placa of Death *(Chack only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar *(Specify)*

27. Manner of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha daath cartificata be axacutad within 24 hours after death.

To the Funaral Director: After this cartificata has been signad by the attending physician and completely filled in by the funaral director, paga 2 should be datachad for usa as the burial-transit

10

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, daath occurrad at the tima, date and placa, and due to the ceuse(s) and mannar stated.

29b. Signatura and title of cartifiar: James A. Brown, MD

29c. Licansa number: D07285

29d. Data signad *(Month, Day, Year)*: July 14, 2001

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Type, Print): James A. Brown, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ILYA ABRAMZON

2. Date of Death (Month, Day, Year): JULY 14, 2001

3. Time of Death: 7:25 P.M.

4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-49-4048

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): APRIL 10, 1929

9. Birthplace (State or Foreign Country): UKRAINE

Usual Residence of Decedant

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 10120 NEW HAMPSHIRE AVENUE, # 209

10f. Zip Coda: 20903

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedant's Education (Specify only highest grade compliated): Elementary/Secondary (0-12) / College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Fathar's Nama (First, Middla, Last): MICHAEL ABRAMZON

18. Mothar's Nama (First, Middle, Maiden Sumama): YAHNA BEREZNYTSKAYA

19a. Intormant's Name/Ralationship (Type, Print): OLGA VOLPER - NIECE

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 10014 MAPLE LEAF DRIVE, MONTGOMERY VILLAGE, MD 20886

20a. Mathod ot Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa ot Disposition (Nama of cematery, crematory or othar placa): JUDEAN MEMORIAL GARDENS

Data: 7/17/01

20c. Location - City or Town, Stata: OLNEY, MARYLAND

21. Signatura of Funarel Sarvica Licensaa: Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complicetions that ceused tha death. Do not entar tha moda of dying, such as cardiac or respiretory arrast, shock, or haart tailura. List only ona causa on aach lina.

Approximeta Intarval Between Onset and Death

Immedieta Causa (Final disaasa or condition resulting in death): a. CARCINOMA - COLON

Dua to (or as a consequence of):

Sequentiellly list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b.

Dua to (or as a consequance ot):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa ratarred to medical axaminar? 1 [ ] Yas 2 [✓] No

26. Place ot Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [✓] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, tarm, straat, tactory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best ot my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha time, deta and piece, and dua to the cause(s) and mennar statad.

29b. Signatura and titla of certitiar: Gregory A Compton MD

29c. Licansa number: D24942

29d. Data signed (Month, Day, Year): July 15 2001

30. Nama and address of person who completed cause ot death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6124 Montrose Rd Rockville MD

State Registrar

31. Data tiled (Month, Day, Year): JUL 18 2001

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
GEORGE WOODWORTH BUSHBY	JULY 13, 2001	5:05 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MONTGOMERY GENERAL HOSPITAL	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213 09 6573	1☒M 2☐F	82 Yrs.			SEPT. 2, 1918	NEW JERSEY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	ROCKVILLE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4000 MONTPELIER ROAD	20853	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW II	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	SURVEYOR ENGINEER	LAND SURVEYING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GILBERT BUSHBY	LULU WOODWORTH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
THELMA R. BUSHBY, WIFE	4000 MONTPELIER ROAD, ROCKVILLE, MD. 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METROPOLITAN CREMATORY	7/14/01	ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Muriel H. Barber	MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia — 10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Bennett Morrison MD	D 47682	July, 13, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Bennett Morrison 2901 Olney-Sandy Spring Road, Olney, Maryland, 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 16 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Alice P. Burhoe	July 12, 2001	4:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sunrise Assisted Living of Rockville	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-38-4477	1☐ M 2☒ F	92 Yrs.			Sept. 14,1908	Texas

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Wheaton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10709 Torrance Drive	20902	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
-	5+	Teacher	Montgomery County Public Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roland Philips	Adelaide Adams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sumner Z. Burhoe/ Son	10709 Torrance Drive, Wheaton, Maryland 20902

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	George Washington Cemetery	July 16, 2001	Adelphi, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Will E Bauer Jr M00672	Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Alzheimers Disease	Years
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnancy 4☐ Pregnant et time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ P. Talwar MD.	D36552	July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pankaj Talwar, M.D., 50 W. Edmonston Drive, #401, Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19b, 7/26/2001, BMW, Montg.Co.

Certificate of Death

Reg. No. 2001 24455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Afrika L. Brice
2. Date of Death (Month, Day, Year): July 15 2001
3. Time of Death: 0927
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 071-60-5273
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 26 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 11, 1975
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13015 Payton Drive
10f. Zip Code: 20774
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 3yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Cal Brice
18. Mother's Name (First, Middle, Maiden Surname): Jennifer Prease

19a. Informant's Name/Relationship (Type, Print): Julia Brice (grandMother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~137 Downing St~~ 1371 Downing Street, N.E. Washington, DC 20018

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery — Date: 7-20-01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th St,N.W. Washington, DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Severe Metabolic Acidosis
Due to (or as a consequence of):
b. Self-induced medication overdose

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OVARIAN CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): July 15 2001
28b. Time of Injury: 0100 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Patient took an overdose of prescription medications
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 13015 Payton Drive Upper Marlboro, Maryland 20774

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: Salvador Sylvester, M.D.
29c. License number: MD053927
29d. Date signed (Month, Day, Year): July 15 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24456

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN KANTOR BORUSHOK

2. Date of Death (Month, Day, Year): JULY 12, 2001

3. Time of Death: 10:00 AM

4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 257-76-1439

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 18, 1907

9. Birthplace *(State or Foreign Country)*: RUSSIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4803 RIM ROCK ROAD

10f. Zip Code: 20853

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: HYMAN KANTOR

18. Mother's Name *(First, Middle, Maiden Surname)*: FANNY "UNAVAILABLE"

19a. Informant's Name/Relationship *(Type, Print)*: RENEE KREISMAN/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4803 RIM ROCK ROAD, ROCKVILLE, MARYLAND 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOUNT LEBANON CEMETERY

Date: JULY 15, 2001

20c. Location - City or Town, State: ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. INFECTED PRESSURE ULCER OF FEET

Due to (or as a consequence of):

c. —

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D 18084

29d. Date signed *(Month, Day, Year)*: JULY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24457
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Joseph	Eugene	Bonin	July	15,	2001	2:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
046-09-8241	1 X M 2 F	83 Yrs.					Jan. 18, 1918	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Damascus	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25711 Valley Park Terrace	20872	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	Oil Company

To Be Completed by Funeral Director

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Emeede Bonin	Lillian E. Bourey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann Bonin/wife	25711 Valley Park Terrace, Damascus, MD 20872

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Chesapeake Crematory	July 17, 2001	Beltsville, MD

21. Signature of Funeral Service Licensee: Stella D. Lohmann

22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. ischemic cardiomyopathy — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest

b. Anoxic Encephalopathy — months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Wes decedent pregnent in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24e. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical exeminer? 1 Yes 2 X No

28. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 X Other (Specify) (Hospice Casey)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 **Medicaf Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D35635	July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Kaplan, M.D. 18111 Prince Phillip Drive, Olney, MD 20832

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrar's Signature
JUL 17 2001	Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #16,18b,7/19/2001,BMW.Montg.Co. **Certificate of Death** Reg. No. 2001 24458

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9+1

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FANNIE BOND
2. Date of Death Month Day Year: JULY 15, 2001
3. Time of Death: 9:06 A M
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 417-34-6932
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 26, 1927
9. Birthplace (State or Foreign Country): NEW YORK

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: LAUREL
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 9001 CHERRY HILL RD.
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE DIRECTOR
18b. Kind of Business/Industry: HOSP'T HOWARD UNIVERSITY

17. Father's Name (First, Middle, Last): THORTON WOOD
18. Mother's Neme (First, Middle, Meiden Surneme): ~~HOSP'T~~ EUGENE V. BOOZE

19a. Informant's Name/Relationship (Type, Print): ARTHUR STALKS/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1207 N ST. N.W. #C, WASHINGTON, D.C. 20005

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): CHAMBERS CREMATORY
Date: 7-18- 2001
20c. Location - City or Town, Stete: RIVERDALE, MD.

21. Signeture of Funeral Service Licepsee: W.W. Chambers M00091
22. Name and Address of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES,P.A., RIVERDALE, MD.20737

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death: 3 DAYS

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS
Due to (or as a consequence of):
Sequentiafly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last: b. URINARY TRACT INFECTION
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an eutopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause ol death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one) Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)
27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D24721
29d. Date signed (Month, Dey, Yeer): JULY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED A. SADIQ, M.D. 14333 LAUREL BOWIE RD., LAUREL, MD. 20708

State Registrar

31. Date filed (Month, Day, Yeer): JUL 19 2001
32. Registrar's Signature: Jennie G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 24459

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Maria Iluminada Bolorino	July 15, 2001	5:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12806 Teaberry Road	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-54-5594	1☐M 2☒F	83 Yrs.			Nov 29, 1917	Ecuador

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
12806 Teaberry Road	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☒Yes 2☐No Specify: Ecuadorian	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work duning most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Waitress	Food Service

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Juan Bautista Bolorino Batallia	Maria Fidela Salvatierra

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Consuelo Mercedes Canales (Daughter)	12806 Teaberry Road, Silver Spring, MD 20906

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	Gate of Heaven Cemetery	July 18, 2001	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert A Dyson	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Bronchioalveolar Carcinoma	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or es a consequence of):	
	c. Due to (or es a consequence of):	
	d. Due to (or es e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

23e. Did tobecco use contribute to the cause of death?	24e. Was en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No 3☐Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted.
2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Jose Bonelli MD	D 35055	July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jose Bonelli, MD 8807 Colesville Road, 5th Floor, Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Yes

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GUSTAV HEINZ BOLHOFF

2. Date of Death: Month JULY Dey 16, Year 2001

3. Time of Death: 1:50 AM

4a Facility Name (If not institution, give street end number): NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-07-5079

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 102 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 5, 1898

9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 905 LINCOLN ST.

10f. Zip Code: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAITER

16b. Kind of Business/Industry: HOTEL

17. Father's Name (First, Middle, Last): HEINRICH GUSTAV BOLHOFF

18. Mother's Name (First, Middle, Maiden Surname): EMMA DICKTON

19a. Informent's Name/Reletionship (Type, Print): HEINZ D. BOLHOFF/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 905 LINCOLN ST., ROCKVILLE, MD. 20850

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Ptece of Disposition (Name of cemetary, cremetory or other place): CHAMBERS CREMATORY

Date: 7/18/01

20c. Location - City or Town, Stete: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers MO0091

22. Name end Address of Fecility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MEM

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel diseesa or condition resulting in deeth)

a. pneumonia — 7 days

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. congestive heart failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et tha time, data end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D500612

29d. Data signed (Month, Day, Year): July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMUEL MAILER, M.D. 19500 AMARANTH DR. #B, GERMANTOWN, MD. 20874

State Registrar

31. Dete filed (Month, Day, Year): JUL 18 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24461

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary G. Bolden
2. Date of Death Month Day Year: July 11, 2001
3. Time of Death: 9:45 PM
4a Facility Name *(If not institution, give street and number)*: Mariner Health of Kensington
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-60-5594
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 15, 1915
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1304 Van Buren Street N.W.
10f. Zip Code: 20012
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Phillip Gibson
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Hughes

19a. Informent's Name/Relationship *(Type, Print)*: Eloyce W. Brooks, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6021 - 7th Place N.W., Washington, D.C. 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: 7/16/01
20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: Joanna E. Ellsbury
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Bladder CA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Keith Damsker MD
29c. License number: D0057019
29d. Date signed *(Month, Day, Year)*: July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Keith Damsker, MD 2309 Shorefield Road Wheaton MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Arthur Alexander Biller, Jr.	July 17, 2001	9:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-56-2589	1 [X] M 2 [ ] F	49 Yrs.			July 27, 1951	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Olney	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4509 Cannes Lane	20832	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Mechanic	Automobile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Arthur Alexander Biller, Sr.	Betty Marie Arehart

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Amy J. Biller / Wife	4509 Cannes Lane, Olney, MD 20832

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Gate of Heaven Cemetery	July 20, 2001	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert C Ramey	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Variceal Bleeding	36 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Alcoholic liver Disease	10 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Oete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John Snyder	D18726	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Arthur Schoengold, MD 18101 Prince Philip Dr, Olney MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** MCP

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#10g,17,18,7/25/2001,BMW,Reg.Co

Certificate of Death

Reg. No. 2001 24463

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Satyabhama	Madhao	Bhumralkar	July 16, 2001	3:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
724 Ivy League Lane	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212 25 1738	1☐ M 2☒ F	88 Yrs.			Aug. 12, 1912	India

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
724 Ivy League Lane	20850	India ~~United States~~

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Waman Krishnarao Charwekar	Laxmi Waman Charwekar (Unavailable)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Krishnakant Bhumralkar / Son	724 Ivy League Lane, Rockville, MD 20850

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	July 18, 2001	Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann

22. Name and Address of Facility: Kemp Funeral and Cremation Services
Stephen D. Lohrmann P.A.
933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Carcinoma of Liver	2 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Carcinoma of Gallbladder	2 weeks
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John B.K. Allotey M.D.	D25232	07-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John B.K. Allotey, M.D. 12450 Parklawn Drive, #102 Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angelo Bernardi
2. Date of Death: Month July, Day 14, Year 2001
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): Manor Care Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 101-10-0800
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 103 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 13, 1898
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9515 Launsberry Court
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Furrier
16b. Kind of Business/Industry: Clothing Manufacturing

17. Father's Name (First, Middle, Last): Octavio Bernardi
18. Mother's Name (First, Middle, Meiden Surname): Marie (UNK)

19a. Informent's Name/Relationship (Type, Print): Richard Bernardi/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4911 Aurora Drive, Kensington, MD 20895

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, crematory or other place): Chesapeake Crematory
Date: July 17 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohmann
22. Name end Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave.Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death)
e. Aspiration Pneumonia

Due to (or es e consequenca of):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest
Due to (or es e consequence of):
c. Dementia

Due to (or as e consequenca of):
d. Urinary Incontinence

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauae of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Kirti Vohra M.D
29c. License number: D20274
29d. Date signed (Month, Day, Year): July 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kirti Vohra, MD 7710 Bradley Blvd. Bethesda, MD 20817

State Registrar

31. Dete filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24465

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLINTON RALPH BERGER
2. Date of Death Month: JULY Day: 12, Year: 2001
3. Time of Death: 5:20PM
4e. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 086-05-7011
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 1, 1911
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6111 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRINTER
16b. Kind of Business/Industry: COMMERCIAL

17. Father's Name (First, Middle, Last): WILLIAM FRANK BERGER
18. Mother's Name (First, Middle, Maiden Surname): LOUISA EISNER

19a. Interment's Name/Relationship (Type, Print): SUZANNE M. BODEN / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13914 CASTAWAY DRIVE, ROCKVILLE, MD 20853

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RIVERSIDE CEMETERY
Date: 07/15/01
20c. Location - City or Town, State: SADDLE BROOK, NJ

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. MYOCARDIAL INFARCTION — 5min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory A Compton MD
29c. License number: D24942
29d. Date signed (Month, Day, Year): July 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6124 Montrose Rd Rockville MD

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Margaret Tucker Bein	July 14, 2001	10:45 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-07-2616	1☐M 2☒F	92 Yrs.			November 18, 1908	Washington, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2019 LansdowneWay	20910	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Clerical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Elwood Tucker	Emma Byron

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Stables/ Power of Attorney	12704 Lamppost Lane Potomac, MD 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify)	Geo. Wash. University Medical Center	July16,2001	Washington, D.C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D42918	July 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Gull Chablani, M.D.	1119 Rockville Pike Suite 316 Rockville, MD 20857

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD J. BEEDE SR.
2. Date of Death: Month July Day 10 Year 2001
3. Time of Death: 2017
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 296-18-8727
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 8 1923
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8802 Gingerbread Court
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 46- 49
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing

17. Father's Name (First, Middle, Last): Harry Beede
18. Mother's Name (First, Middle, Maiden Surname): Ella Hillman

19a. Informant's Name/Relationship (Type, Print): Helen L. Beede/ Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8802 Gingerbread Court , Gaithersburg, MD 20877

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: July 12 2001
20c. Location - City or Town, State: Alexandria , Virginia

21. Signature of Funeral Service Licensee: Tracy A. Stuver
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC Obstructive Pulmonary Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph A Ball MD
29c. License number: D53317
29d. Date signed (Month, Day, Year): July 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH Ball 16220 FREDERICK ROAD Suite 213 GAITHERSBURG MD 20877

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001
32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

b

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24468

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Benton Barnabas
2. Date of Death Month Day Year: July 16, 2001
3. Time of Death: 4:56 PM

4a Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-58-8268
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 15, 1934
9. Birthplace *(State or Foreign Country)*: India

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8404 Hartford Ave
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Programmer
16b. Kind of Business/Industry: Computers

17. Father's Name *(First, Middle, Last)*: Abraham William Barnabas
18. Mother's Neme *(First, Middle, Maiden Surname)*: Sunderamma Shadrach

19a. Informant's Name/Relationship *(Type, Print)*: Delphine S. Benton Ally/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 13905 Darnestown Rd, Gaithersburg, MD 20878

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: George Washington Cem
Date: Jul 21
20c. Location - City or Town, Stete: Adelphi, MD

21. Signature of Funeral Service Licensee: ▶ Alan J. Donnell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Failure
Due to (or as a consequence of):
b. Colon Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Liver Metastasis
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: ▶ WALLMARK M.D.
29c. License number: 53177
29d. Date signed *(Month, Day, Year)*: July 18, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Johm Wallmark, MD 9707 Mecical Center Drive, #300, Rockville, MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Nanokhanom	K.	Baghdasarian	July	17,	2001	2:44 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-17-1188	1☐ M 2☒ F	80 Yrs.					April 17,1921	Iraq

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Montgomery	Germantown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
19120 Willow Spring Drive	20874	Iran

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Nanny	Child Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ghraman Baghdasarian	Sanam (Unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert Baghdasarian (Son)	19932 Choctaw Court, Germantown, Md. 20876

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Gate of Heaven Cem.	July 19, 2001	Silver Spring, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Curtis E. Day	DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC BREAST CANCER	YRS.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D 35635	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Kaplan 18111 Prince Philip Dr. Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)*	32. Registrar's Signature
JUL 19 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24470

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Frieda BALOTIN
2. Dete of Death Month/Dey/Year: July 17, 2001
3. Time of Death: 12:00 PM
4e. Facility Neme *(If not institution, give street and number)*: Hebrew Home of Greater Washington
4b. City, Town, or Location of Deeth: Rockville
4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 579-54-5879
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthdey)*: 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: April 11, 1914
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3343 S. Leisure World Blvd.
10f. Zip Code: 20906
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐Yes 2☒No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 3
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Partner
16b. Kind of Business/Industry: Independent Pharmacy

17. Fether's Neme *(First, Middle, Last)*: Morris Etelson
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Eva Posner

19e. Informent's Neme/Reletionship *(Type, Print)*: Betty Anne Levy, daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 11403 Hounds Way, Rockville, MD 20852

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Judean Memorial Gardens
Dete: 07/19/01
20c. Location - City or Town, Stete: Olney, MD

21. Signature of Funeral Service Licensed:
22. Neme end Address of Fecility: Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Acute Myocardial Infarction — 4hrs
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobecco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
26. Piece of Deeth *(Check only one)*: Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2☐**Medicel Exeminer:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.
29b. Signature and title of certifier: Gregory Compton MD
29c. License number: D24942
29d. Dete signed *(Month, Dey, Yeer)*: July 17 2001
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUL 20 2001
32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24471

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William S. Balderston
2. Date of Death (Month, Day, Year): July 17, 2001
3. Time of Death: 5:30 A M
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-44-3920
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 19, 1911
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3314 Densmore Court
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Economist
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Thomas M. Balderston
18. Mother's Neme (First, Middle, Meiden Surname): Katherine Purcell

19a. Informant's Name/Relationship (Type, Print): A. Carolyn Balderston/ Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3314 Densmore Court, Silver Spring, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Norbeck Memorial Park
Dete: July 21, 2001
20c. Location - City or Town, Stete: Olney, MD

21. Signature of Funeral Service Licensee: Robert P. Lyon
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia — 3 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Partial Small Bowel Obstruction
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

tF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribule lo the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [X] Unknown
24e. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dale end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frank Lin MD
29c. License number: D43199
29d. Date signed (Month, Dey, Yeer): July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank Lin, MD 10801 Lockwood Dr. #325 Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001
32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29a per Physician 07/20/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 24472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES LEWIS BLIZZARD
2. Data of Death Month Day Year: JULY 19, 2001
3. Time of Death: 12:01 PM

4a. Facility Name (If not institution, give street and number): 1847 OLD WESTMINSTER PIKE
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 217-30-6568
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 10/28/1934
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1847 OLD WESTMINSTER PIKE
10f. Zip Code: 21157
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: UTILITY CO.

17. Father's Nama (First, Middle, Last): ROSCOE BLIZZARD
18. Mother's Name (First, Middle, Maiden Surname): ONEIDA SYKES

19a. Informant's Name/Relationship (Type, Print): JANIS O. BLIZZARD -WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157: 1847 OLD WESTMINSTER PIKE, WESTMINSTER, MD.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): METRO CREMATORY
Date: 7/20/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: R Lang Fletcher
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
a. Immediate Cause (Final disaase or condition resulting in death)	Aspiration Pneumonia	1 week
Due to (or as a consequence of):		
b.	Diffuse encephalopathy	> 1 week
Due to (or as a consequence of):		
c.	Anoxic Brain Damage	> 1 wk
Due to (or as a consequance of):		
d.	Respiratory arrest	> 1 wk

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of cocaine Substance Dependence in June 2001; History of chronic alcoholism

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicet examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Michael A Hyle MD
29c. License number: D27693
29d. Data signed (Month, Day, Year): 7/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A Hyle MD 6530 Walther Ave. Baltimore MD 21206

WJL 5+ IVA +4

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature: Jenna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-4160-033

JAMES CARVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 080701:ITEMS#1,23a,27 per ME G798 ss

Certificate of Death

2001 24473

Reg. No.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

State Registrar

1. Decedent's Name *(First, Middle, Last)*: James Richard Carver, ~~Sr.~~

2. Date of Death Month / Day / Year: JULY 23, 2001

3. Time of Death: 8:35A.M.

4a. Facility Name *(If not institution, give street and number)*: 4309 A SILVER HILL ROAD

4b. City, Town, or Location of Death: SUITLAND

4c. County of Death: PRINCE GEORGES

5. Social Security Number: 577 64 2947

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 26, 1947

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4309 A Silver Hill Road

10f. Zip Code: 20746

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Telephone Company

17. Father's Name *(First, Middle, Last)*: Jack Carver

18. Mother's Name *(First, Middle, Maiden Surname)*: Beulah Catterton

19a. Informant's Name/Relationship *(Type, Print)*: Louise Carver, (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4309 A Silver Hill Road, Suitland, Maryland 20746

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery

Date: July 27, 2001

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Kelli A. Pitt

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* SCENE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Knelsell

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JULY 24,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYSANN A. KOKOR MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed *(Month, Day, Year)*: AUG 0 3 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jeanne Banks Cooper	July 13, 2001	9:52PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Springbrook Nursing Home	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-62-1360	1☐ M 2☒ F	82 Yrs.			Dec. 8, 1918	Washington, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
N/A	N/A	Washington, D.C.	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1241 Kenyon Street, N.W.	20010	United States

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Banks	Lucille Lee

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anthony Cooper Son	1429 Locust Road, N.W., Washington, D.C. 20010

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arlington National	7/24/01	Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ Thomas G. Clyburn

22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARRHYTHMIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

MULTIPLE DECUBITI

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D19609	JULY 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMAN R. TULI, M.D. 3503 PERRY STREET SUITE B MT RAINIER, MD 20712

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 19 2001	▶ G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Patricia	Rose	Cole	July	18	2001	9:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9701 Fields Road #1900	Gaithersburg	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
199-30-7932	1☐ M 2☒ F	61 Yrs.			July 24, 1939	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Gaithersburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9701 Fields Road #1900	20878	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Real estate	Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John C. Cole	Letitia Young

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gordon Cole / Brother	10515 Powell Road , Thurmont, MD 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Slippery Rock Cemetery	July 21 2001	Ellwood City, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Tracy A. Stuver	DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Cardiac Death — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atherosclerosis — years — Due to (or as a consequence of):

c. Diabetes — years — Due to (or as a consequence of):

d. — Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Larynx Cancer

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ John R. Melnick	D 19294	July 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John R. Melnick, M.D. 911 Russell Avenue Gaithersburg, Maryland 20879

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24476

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frank G. Clifford	July 14, 2001	5:19 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
012-26-2292	1☒M 2☐F	78 Yrs.			February 10, 1923	Ohio

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5708 Stillwell Road	20851	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Mechanic	Heating and Air Conditioning

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
George Clifford	Emma Kost

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
H. Ruth Clifford/Wife	5708 Stillwell Road, Rockville, Maryland 20851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Montgomery Crematorium	July 16, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00335	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hyperkalemia — 1 Hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Acute Renal Failure — 1-2 Days
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other (specify) _____ 9☐Unknown	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Virginia Colliver MD	54597	JULY 14, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Virginia C. Colliver, M.D. 6410 Rockledge Drive, #200, Bethesda, Maryland 20817

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 24477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa K. Chen

2. Date of Death: Month July Day 12 Year 2001

3. Time of Death: 6:25 P M

4a. Facility Name (If not institution, give street and number): 11808 Winterset Terrace

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 228-72-0532

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 12, 1943

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 111 Manette Court

10f. Zip Code: 20878

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Biologist

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Ming Kang

18. Mother's Name (First, Middle, Maiden Surname): Shian Hwa Wang

19a. Informant's Name/Relationship (Type, Print): Daniel T. Chen / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Manette Court Gaithersburg, MD 20878

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: July 14, 2001

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GLIOBLASTOMA MULTIFORME — 1½ YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Son's Residence

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: DC19757

29d. Date signed (Month, Day, Year): JULY 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Hawkins, M.D. 110 Irving St., N.W. Washington, D.C. 20010

State Registrar

31. Date filed (Month, Day, Year): JUL 16 2001

32. Registrar's Signature ▶

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24478

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillypuram Caleb Charles
2. Date of Death Month Day Year: July 16, 2001
3. Time of Death: 5:58 AM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-15-3470
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 96 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1905
9. Birthplace *(State or Foreign Country)*: India

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1910 Hampshire Drive
10f. Zip Code: 20783
10g. Citizen of What Country?: India

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* East Indian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Minister
18b. Kind of Business/Industry: Adventist Church

17. Father's Name *(First, Middle, Last)*: Caleb Charles
18. Mother's Neme *(First, Middle, Maiden Surname)*: (Unobtainable)

19a. Informant's Name/Relationship *(Type, Print)*: Rajan Charles/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1912 Hampshire Drive Adelphi, MD 20783

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Geo. Washington
Date: 07/20/01
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Anthony L. Dimmy
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
c. ATHEROSCLEROSIS
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnency: 1 [ ] Live birth 2 [ ] Fetel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Dete of delivery Month Day Year

Pert II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24e. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examinar:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Mukhtar
29c. License number: D19991
29d. Date signed *(Month, Day, Year)*: 07/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. SUDHAKAR, MD 7610 CARROLL AVE #230, TAKOMA PARK MD 20912

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001
32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
GEORGE J. CHACONAS	July 13 2001	7:45 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUBURBAN HOSPITAL	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-20-1413	1☒ M 2☐ F	81 Yrs.			Sept. 1, 1919	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1123 Maple Avenue	20851	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 07/42 to 12/45	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Manager	Montgomery County

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Harry Chaconas	Athena Liaskos

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Crystal C. Alexander/Daughter	1007 Crown Street, Mt. Airy, Maryland 21771

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Fort Lincoln Ceme.	07/17/2001	Bladensburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nancy A. Pescente	JOSEPH GAWLER'S SONS, INC. 5130 Wisc. Avenue, NW, Washington, D.C. 20016

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lung Cancer	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Encephalopathy

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M.D.	D54347	JULY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NEERAJ CHOPRA 121 CONGRESSIONAL LANE #409, ROCKVILLE, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Chaconas, George 7/13/01 1945

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 16 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 24480
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RUTH Z. CARRINGTON	JULY 18, 2001	5:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8911 Pennsylvania Ave.	Silver Spring	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
246-38-3506	1☐ M 2☒ F	74 Yrs.			Dec.17,1926	S. Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1110 Fidler Lane, #504	20910	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Housewife	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wiley H. Hill	Bessie Burnett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Beverly S. Burke (Daughter)	8911 Pennsylvania Ave., Silver Spring, MD 20910

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cem.	7/21/01	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Pancreatic Carcinoma	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughters Home

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D32033	July 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter G. Hamm, M.D. 5454 Wisconsin AVe. #1125, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Tommy Lee Conley	July	21	2001	11:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2 Union Street	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-62-2538	1☒M 2☐F	46 Yrs.			July 29 1954	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Westminster	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2 Union Street	21157	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Glazier	Lane Window Repair

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Kemper Conley	Helen Shifflett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Diane Conley/wife	2 Union Street Westminster, MD 21157

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Zion Church Cemetery	7/24/2001	Westminster, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC LUNG CANCER	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☑Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Flavio Kruter	D55398	7-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flavio Kruter, MD 55 South Center Street Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 23 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 5

Amend Item#24a,27 perPHYG798 8/16/01 EW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#1,(per MD), State of Maryland / Department of Health and Mental Hygiene

Amendeditem 1- For State Registrar 07-19-01,TCHD,SRR *Certificate of Death* Reg. No. 2001 24482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY LEE BYRNE ~~CHOLLET~~ CHOLLET

2. Date of Death: Month July Day 16, Year 2001

3. Time of Death: 1840 M

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 216-20-6971

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 2,1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Tilghman

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4909 Fairbanks Rd.

10f. Zip Code: 20671

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify: X

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Telephone Co.

17. Father's Name (First, Middle, Last): John B. Byrne

18. Mother's Name (First, Middle, Meiden Surname): Mary Alice Lee

19a. Informent's Name/Relationship (Type, Print): Raymond H. Chollet Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4909 Fairbanks Rd. Tilghman, Maryland 20671

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Capitol Crematory Date: July 18, 2001

20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: Harrison E. Leonard

22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)
a. Massive (R) Cerebral

Due to (or as a consequence of):
b. Hemorrhage with Brain — 7 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Herniation and Subsequent

Due to (or as a consequence of):
d. Respiratory Cessation

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure
Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Detrich M.D.

29c. License number: D12893

29d. Date signed (Month, Day, Year): 7-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Terry P. Detrich M.D. 140 S. Washington St. Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): JUL 19 2001

32. Registrar's Signature: B. Hoots

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Chollet, Mary Lee

TALBOT

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24483

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BILLYE DEL MEDICO

2. Data of Death — Month: JULY; Day: 16; Year: 2001

3. Time of Death: 1:18 P. M.

4a. Facility Name *(If not institution, give street and number)*: 1801 EAST JEFFERSON STREET APT. 439

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 090-07-7896

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: DEC. 19, 1909

9. Birthplace *(State or Foraign Country)*: NEW YORK

Usual Rasidence of Decedant

10a. Stata: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1801 EAST JEFFERSON STREET, APT. 439

10f. Zip Code: 20852

10g. Citizen of What Country?: U. S. A.

11. Maritel Stetus: 1☐ Never Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12); College (1-4or 5+): 4 YEARS

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: SCHOOL SECRETARY

16b. Kind of Businass/Industry: EDUCATION

17. Fathar's Nama *(First, Middla, Last)*: SAMUEL STRAUSBERG

18. Mothar's Name *(First, Middla, Maiden Surnama)*: SARAH DONEFER

19a. Informant's Name/Ralationship *(Type, Print)*: SHARON K. LIEBLICH - DAUGHTER

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1600 NORTH OAK STREET, # 714, ARLINGTON, VA. 22209

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: CYPRESS HILLS CEMETERY

Data: 7/18/01

20c. Location - City or Town, Stata: BROOKLYN, NEW YORK

21. Signatura of Funaral Sarvica Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiretory errest, shock, or heart failura. List only ona causa on aach line.

Approximata Intarval Batween Onsat and Death

Immediete Cause (Final disaasa or condition resulting in death): a. Lung Cancer

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immedieta cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last:

b.

Dua to (or as a consequanca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings eveilable prior to completion of causa of daath? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mennar steted.

29b. Signature and title of certifier: Gary B. Wilks MD

29c. Licensa number: D 55258

29d. Data signed *(Month, Day, Year)*: July 16, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Gary B. Wilks, MD 1801 East Jefferson Street Rockville Maryland 20852

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 18 2001

32. Registrar's Signatura: G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be axcuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Roberto De Santis	July 16, 2001	3:32 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1[X] M 2[ ] F	83 Yrs.			Apr 17, 1918	Italy

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Italy	Rome	Manziana	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Via Casale delle Grazie	None	Italy

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Accountant	Government of Italy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Agostino De Santis	Elvira Fraleoni

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Adriana De Santis de Tommaso / (daughter)	8500 Buckhannon Drive, Potomac, MD 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Manziana Cemetery	July 27, 2001	Manziana, Rome, Italy

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	about 1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D45014	July 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Isabelle C. Martire 8379 Cherry Lane, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	▶ [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Teresa M. DeFerrari	07 / 16 2001	10:20A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care-Potomac	Potomac	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-66-6466	1☐ M 2☒ F	71 Yrs.			Feb. 21, 1930	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
none	none	Washington, DC	☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3820 Argyle Terrace, NW	20011	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	5	Teacher-Administrator	Education

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Roy J. DeFerrari	Evelyn M. Biggi

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Austin DeFerrari/Brother	3820 Argyle Terrace, NW., Washington, DC 20011

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	Gate of Heaven Cem.	July 18, 2001	Silver Spring, Md.

21. Signature of Funeral Service Licensee	22. Name end Address of Fecility
John F. Dubel	DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in death)	e. Alzheimer's Disease	years
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or es a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of exemineticn and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Michael J Grady MD	D0038781	7/16/01

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)
Michael J. Grady, MD., 4910 Massachusetts Ave., NW., Washington, DC

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
JUL 18 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** MCH

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2 (3)

01-3906-031
jhm
WAYNE HENRY
DAVIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24486

UNPENDED 080301: ITEMS#23a,27,28a-f per ME G798 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WAYNE H. DAVIS
2. Date of Death (Month, Day, Year): JULY 14, 2001
3. Time of Death: 04:20 AM
4a. Facility Name (If not institution, give street and number): 14600 MOUNT NEBO ROAD
4b. City, Town, or Location of Death: POOLESVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216-50-7969
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.25,1949
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Poolesville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 18550 Jerusalem Church Road
10f. Zip Code: 20837
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 70-76
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): | College (1-4or 5+): 1 yr.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Farm Hand
17. Father's Name (First, Middle, Last): James H. Davis
18. Mother's Name (First, Middle, Maiden Surname): Patsy L. Lyles
19a. Informant's Name/Relationship (Type, Print): Patsy L. Davis (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18550 Jerusalem Church Rd., Poolesville, MD 20837
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Elijah Church Cem.
Date: 7/20/01
20c. Location - City or Town, State: Poolesville, MD
21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Batween Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. COCAINE INTOXICATION
Due to (or as a consaquence of):
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury thet initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cesa raferred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day, Year): found 7-13-01
28b. Time of Injury: found at: 8:00 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 14600 Mt. Nebo Rd. Poolesville, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature end title of certifier: Marjorie McGrell ME
29c. License number: OCME
29d. Date signed (Month, Day, Year): JULY 15, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MARYANN A. KOLCH 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b, 7/20/2001, MEM, Montg. Co

Certificate of Death

Reg. No. 2001 24487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha S. Davis
2. Date of Death (Month, Day, Year): July 13, 2001
3. Time of Death: 5:00pm
4a. Facility Name (If not institution, give street and number): Independence Court Nursing Center
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Geroge's

Funeral Director

5. Social Security Number: 578-32-8092
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1918
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3910 Commander Drive
10f. Zip Code: 20782
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant
16b. Kind of Business/Industry: DC Public Schools

17. Father's Name (First, Middle, Last): Frank Steele
18. Mother's Name (First, Middle, Maiden Surname): Annie Laura Bell

19a. Informant's Name/Relationship (Type, Print): Diane Lindsay- Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3910 Commander Drive, Hyattsville, MD 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
7 Date: 6/18/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Joanna E. Ellsberry
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Alzheimer's Disease	4 yrs.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Myeloproliferative Disease	12 yrs.
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: DC 4360
29d. Date signed (Month, Day, Year): July 16, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dal Yoo, M.D. 1160 Varnum Street, N.E. Ste. #217, Washington, D.C. 20017

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: Deputy G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #24a, 7/17/2001, BMW, Montg. Co AMEND ITEM# 1 per phys G798 082901 ss *Certificate of Death*

Reg. No. 2001 24488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary Virginia Dato	June 29 2001	1125 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical System	Baltimore	–

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-56-7009	1☐M 2☒F	63 Yrs.			April 23, 1938	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13902 Shippers Lane	20853	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Vice President	Association/BILASHA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William McClaren	Mary Virginia Schantz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Daniel P. Dato/Husband	13902 Shippers Lane, Rockville, Maryland 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Montgomery Crematorium	July 5, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Multi-Organ System failure

Due to (or as a consequence of):
b. Intra-Abdominal Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Incarcerated Hernia

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Fungemia,

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	P13891	June 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ben Lowentritt, MD 22 S. Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	[signature] B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 24489

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Raymond Dean

2. Date of Death (Month, Day, Year): July 19 2001

3. Time of Death: 0615

4a. Facility Name *(If not institution, give street and number)*: 205 Choptank Avenue

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-12-0456

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 11 1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 205 Choptank Avenue

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: shift supervisor

16b. Kind of Business/Industry: wire belt mfg.

17. Father's Name *(First, Middle, Last)*: Ray Whitmore Dean

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Elizabeth Warfield

19a. Informant's Name/Relationship *(Type, Print)*: Katherine Dean - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 205 Choptank Ave., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery — Date: 7/23

20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R Thomas Jr.

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pancreatitis with pseudocyst	6-7 Wks
Due to (or as a consequence of): b.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure requiring dialysis
Anemia due to renal failure
Cardiovascular disease not classified

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lawrence D Bohan MD

29c. License number: D-27409

29d. Date signed *(Month, Day, Year)*: 7-20-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence D. Bohan, M.D. 505 Dutchman's Lane, Easton, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 20 2001

32. Registrar's Signature: ▶ Bonnie G. Jones

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Falls

01-3874-003
crn
Karen Lynn Etchison

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 080301:ITEMS#23a,b,27,28a-f per ME G798 SS

Certificate of Death

Reg. No. 2001 24490

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Karen L. Etchison
2. Date of Death Month: July Day: 12 Year: 2001
3. Time of Death: 7:35 A.M.
4a Facility Name *(If not institution, give street and number)*: 2202 Dairy Farm Road
4b. City, Town, or Location of Death: Gambrills
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-54-9264
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 35 Yrs. If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 31, 1965
9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2202 Dairy Farm Road
10f. Zip Code: 21054
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): - ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Grant Specialist
16b. Kind of Business/Industry: United States Government

17. Father's Name *(First, Middle, Last)*: James Lloyd Harris
18. Mother's Name *(First, Middle, Maiden Surname)*: Doris (Unavailable)

19a. Informant's Name/Relationship *(Type, Print)*: Elgin M. Etchison, Jr./Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2202 Dairy Farm Road, Gambrills, Maryland 21054

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.
Date: July 15, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ Will E Bowman Jr M00672
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ANTI-DEPRESSANT (BUPROPION) INTOXICATION
Due to (or as a consequence of):
DEPRESSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* at scene

27. Menner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: found: 7-12-01
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject ingested drug
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: found: residence
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 2202 Dairy Farm Rd. Gambrills, Anne Arundel County, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) and manner es stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and ptaca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 17 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAUREL C. FRAZIER
2. Date of Death (Month, Day, Year): July 13, 2001
3. Time of Death: 6:10 AM
4a. Facility Name (If not institution, give street and number): Shady Grove Nursing Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-09-2222
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 102 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 19, 1899
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 11020 Brink Road
10f. Zip Code: 20876
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Boiler Engineer
16b. Kind of Business/Industry: Suburban Hospital

17. Father's Name (First, Middle, Last): Isaiah Frazier
18. Mother's Name (First, Middle, Maiden Surname): Jeanna ?

19a. Informant's Name/Relationship (Type, Print): Francis Frazier (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11020 Brink Rd., Germantown, MD 20876

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Brooke Grove Cem. | Date: 7/19/01
20c. Location - City or Town, State: Laytonsville, MD

21. Signature of Funeral Service Licensee: Dana K. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia — Minutes
Due to (or as a consequence of):
b. Coronary Artery Disease — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Anemia, Congestive Cardiomyopathy
Aortic stenosis, Advanced Age

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Priscilla Callahan-Lyon MD
29c. License number: D 41794
29d. Date signed (Month, Day, Year): July 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Priscilla Callahan-Lyon, MD 911 Russell Ave Gaithersburg, MD 20879

State Registrar

31. Date filed (Month, Day, Year): JUL 17 2001
32. Registrar's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frederick Michael Frank, Sr.	July 13, 2001	6:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MANOR CARE OF SILVER SPRING	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-07-5623	XX M 2☐ F	87 Yrs.			OCT. 9, 1913	WASHINGTON, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	SILVER SPRING	1☐ Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1326 MIMOSA LANE	20904	UNITED STATES OF AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced	XX Yes 2☐ No If Yes, Give Year or Dates: 1941-1945	1☐ Yes XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	PROCUREMENT OFFICER	DEPARTMENT OF JUSTICE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MICHAEL J. FRANK	EDITH V. BRANZELL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
F. MICHAEL FRANK, JR. (SON)	3205 KILKENNY STREET; SILVER SPRING, MARYLAND 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GATE OF HEAVEN CEMETERY	JULY 19, 2001	SILVER SPRING, MARYLAND

21. Signature of Funeral Service Licensee: ▶ James E. Schwarz

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 WEEKS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNEUMONIA	2 WEEKS
	Due to (or as a consequence of):	
	c. PRESSURE ULCER OF SACRUM	1 MONTH
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably XX Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes XX No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes XX No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: XX Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul Armstrong MD	D43237	July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL ARMSTRONG, M.D., 14201 LAUREL PARK DRIVE, SUTIE 102; LAUREL, MARYLAND 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30 + 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24493

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Louise Fisher

2. Date of Death (Month, Day, Year): July 15, 2001

3. Time of Death: 12:45 PM

4a. Facility Name *(If not institution, give street and number)*: Randolph Hills Nursing Home

4b. City, Town, or Location of Death: Wheaton

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-50-0826

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 16, 1915

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10000 Brunswick Avenue

10f. Zip Code: 20910

10g. Citizen of What Country?: United States

11. Maritel Stafus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Artist/ Provider

16b. Kind of Business/Industry: Child Care

17. Father's Name *(First, Middle, Last)*: Clarence Frazier Fisher

18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Louise VanWagnen

19a. Informant's Neme/Relationship *(Type, Print)*: Anne T. Petzold/Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1212 Millgrove Road, Silver Spring, Maryland 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park

Date: July 19 2001

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Fdneral Service Licensee: ▶ [signature]

22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00335 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Entar the disaase, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Inforval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Acute Myocardial Infarction — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Palsy, Recurrent Aspiration

Atherosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compiation of cause of deeth? 1☐ Yes 2☐ No

25. Was case rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature] Martin C. Shargel M.D.

29c. License number: D08944

29d. Data signed *(Month, Day, Year)*: July 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 17 2001

32. Registrar's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amend Item 26 per Physician, 07/20/2001, Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sterling Richard Fritz
2. Date of Death Month: 07 Day: 16 Year: 01
3. Time of Death: 1411 M
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-38-6011
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 31, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 71 S. Springdale Rd.
10f. Zip Code: 21158
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1962-64
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Dacedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): repairman
16b. Kind of Business/Industry: heating/ air conditioning

17. Fathar's Name (First, Middle, Last): Sterling Carroll Fritz
18. Mothar's Nama (First, Middle, Maiden Sumama): Myra Irene Wetzel

19a. Informant's Name/Raletionship (Type, Print): Peggy Ann Fritz/ wife
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 71 S. Springdale Rd. Westminster, MD 21158

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park Date: 7/19/01
20c. Location - City or Town, Stata: Eldersburg, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler
22. Nama and Address of Facility: Hartzler Funeral home 310 Church St. New Windsor, MD 21776

Physician /Medical Examiner

23a. Part1. Entar the disease, or compticetions that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Daath

Immediata Causa (Finel diseasa or condition resulting in death)
a. Ventricular Tachycardia — 1 min

Dua to (or as e consequence of):
b. CAD — 10yrs

Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in daath) Last
Dua to (or es a consequence of):
c. Hypertension — 25yr

Due to (or as a consequence of):
d. Diabetes — 5yr

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pragnancy 1 ☐ Liva birth 2 ☐ Fatal daath 3 ☐ Ectopic pregnency 4 ☐ Pregnent et time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Pert I.

23e. Did tobecco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to complation of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Was case raferred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Placa of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home ~~5 ☒ Residence~~ 8 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not ba datarmined
28a. Dete of Injury (Month, Day Yeer)
28b. Tima of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, dete end plece, and dua to tha ceusa(s) end mennar as stated. 2 ☐ **Medical Exeminer:** On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signatura and title of certifiar: John W. Middleton
29c. License number: D25443
29d. Date signed (Month, Day, Year): 7-19-2001

30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print): John W. Middleton 688 Poole Road, Westminster md 21157

State Registrar

31. Date filed (Month, Day, Year): JUL 20 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RICHARD BRADLEY GREENSPAN	JULY 18, 2001	5:40AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MONTGOMERY GENERAL	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
097-10-5999	1☒M 2☐F	87 Yrs.			JULY 26, 1913	NEW YORK

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	SILVER SPRING	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15400 BASSETT LANE #3C	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	SUPERVISOR	IRS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MAURICE GREENSPAN	BERTHA DAVIDOVICH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARTHA O. GREENSPAN/WIFE	15400 BASSETT LA #3C, SILVER SPRING, MARYLAND 20906

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	KING DAVID MEMORIALGDN	JUL 20, 2001	FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. RESPIRATORY FAILURE	15 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): CONGESTIVE HEART FAILURE.	1 MONTH
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant condftions** contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONS DISEASE.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D38457	JULY 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. GOYAL MD, 3801 INTERNATIONAL DR #211, S. SPRING, MD 20906

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 24496

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LUBA GOLDENBERG

2. Date of Death Month: July Day: 11th Year: 2001

3. Time of Death: 4:30 Am

4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 133-26-2773

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 7, 1911

9. Birthplace *(State or Foreign Country)*: RUSSIA

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: POTOMAC

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11208 FALL RIVER COURT

10f. Zip Code: 20854

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: AARON SCHERKER

18. Mother's Name *(First, Middle, Maiden Surname)*: PEARL "UNAVAILABLE"

19a. Informant's Name/Relationship *(Type, Print)*: DORA WEINSTEIN/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11208 FALL RIVER CT, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOUNT LEBANON CEMETERY

Date: JULY 13, 2001

20c. Location - City or Town, State: ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20854

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute Cardio-pulmonary arrest

Due to (or as a consequence of):

b. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Chronic cerebral ischemic

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism recurrent Aspiration Pneumonia

dysphagia recurrent urinary tract infections

Osteoporosis Constipation anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Consuelo Alvarez

29c. License number: D:44507

29d. Date signed *(Month, Day, Year)*: July 11th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Consuelo Alvarez, MD 6105 Montrose Road Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 2001

32. Registrar's Signature ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Goldenberg, Luba

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24497

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Esther Gelch	July 17, 2001	1:40a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SPRINGBROOK NURSING HOME	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
131-32-0844	1☐ M 2☒ F	92 Yrs.			JAN 9, 1909	MA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
NY	NASSAU	JERICHO	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
19 SENECA PLACE	11753	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		CLERK	BANKING

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
MORRIS COHEN	DORA UNKNOWN

19a. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
BARRY EPSTEIN-SON	10601 SWEETBRIAR PKWY SILVER SPRING, MD 20903

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BETH DAVID CEMETERY	7/19/2001	ELMONT, NY

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald C. Stottlemyer	DANZANSKY-GODLBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in deeth)	a. Dehydration	1 wk.
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as a consequence of): Impaired Oral Intake	> 1 yr
	c. Due to (or es a consequence of): Advanced Senile Dementia	Many yrs.
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐ Yes 2☑ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism, Bradycardia, Anemia, Hearing Impairment, Arthritis

23e. Did tobecco use contribute to the cause of death?	24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No 3☐ Probebly 4☐ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ [signature] MD	D31001	7/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, MD — 7500 Greenway Cntr. Dr. #430 Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
JUL 18 2001	▶ [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Alberto	M.	Ganz	July 13, 2001	11:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5454 Wisconsin Ave., #925	Chevy Chase	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
284-18-9253	1 [X] M 2 [ ] F	80 Yrs.			February 6, 1921	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	North Chevy Chase	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3600 Dundee Driveway	20815	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Contractor/ Negotiator	U.S. Navy Department

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Ganz	Jane Rivis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Suzanne S. Ganz/ Wife	3600 Dundee Driveway North Chevy Chase, Maryland 20815

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Montgomery Crematorium Inc.	July 14, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00335	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7257 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Thoracic Aortic Aneurysm	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Left Ventricular Dysfunction	
	Due to (or as a consequence of):	
	c. Ventricular Tachycaria	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Dr's Office

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D25818	July 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sean M. Dwyer, MD 5454 Wisconsin Ave., Suite 925, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 17 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24499

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret G. Gallagher
2. Data of Death Month Day Year: July 16, 2001
3. Tima of Daath: 8:50 AM
4a. Facility Nama (If not institution, give street and number): Genesis Eldercare- Layhill Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 184-03-3690
6. Sex: 1☐M 2☒F
7. Aga (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Feb 9, 1911
9. Birthplace (State or Foraign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Insida City Limits: 1☐Yas 2☒No
10e. Street and Number: 14400 Homecrest Road
10f. Zip Coda: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yas 2☒No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fether's Nama (First, Middle, Last): Patrick Nelson
18. Mother's Nama (First, Middla, Maiden Sumama): Mary Ann McGrath

19a. Informant's Name/Relationship (Type, Print): James J. Gallagher / Husband
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda): 14400 Homecrest Road, Silver Spring, MD 20906

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or othar place): Gate of Heaven Cemetery
Data: July 20, 2001
20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funeral Service Licensee: John C. [illegible]
22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximate Intarval Batwaan Onsat end Daath

Immediate Cause (Final disease or condition resulting in death):
a. Parkinson's Disease — 5+ years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Othar (specify) 9☐Unknown
23d. Date of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23a. Did tobacco usa contributa to the causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Wara autopsy findings availabla prior to compiation of causa of death? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Placa of Daath (Check only ona)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Othar: 4☒Nursing Homa 5☐Residence 8☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To tha best of my knowledga, death occurred at the tima, data and placa, and dua to the causa(s) and mannar as steted.
2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and piece, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Wilkinson J. Ninala
29c. Licensa numbar: D 45285
29d. Data signad (Month, Day, Yaar): July 17, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Wilkinson J. Ninala 344 University Blvd., W, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Yaar): JUL 18 2001
32. Registrar's Signatura: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Mon

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 24500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Susan Upperco Goodrich	July 18, 2001	4:15 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4829 Westfield Drive	Hampstead	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-46-5638	1☐ M 2☒ F	45 Yrs.			Dec 9, 1955	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Hampstead	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4829 Westfield Drive	21074	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Bookkeeper	Accounting Firm

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Howard E. Upperco	Betty J. Holbrook

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Herbert Goodrich, husband	4829 Westfield Dr, Hampstead, MD 21074

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Paul's Cemetery	7/21/2001	Arcadia, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven W Cline M00723	Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary insufficiency

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Charles B Marek MD	D 13067	7-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles B. Marek, Jr MD, 9712 Belair Road, suite 100, Baltimore, MD 21236

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 20 2001	▶ Jenna D Sparks

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit